

8/6/2008



KENTUCKY TRANSITIONS

OPERATIONAL PROTOCOL

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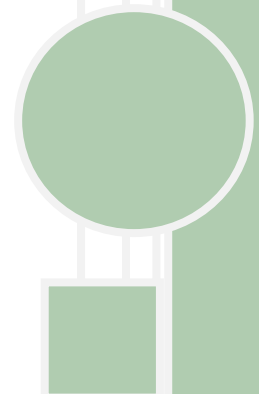


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I. PROJECT INTRODUCTION AND GOALS

Kentucky is embarking upon an intensive effort to rebalance its long-term care system by reducing institutionalization and increasing opportunities for individuals to experience meaningful lives in the community. This effort includes identification and removal of barriers in the current system that are hindering or preventing the transition of Medicaid Members from Nursing Facilities and ICF/MR's into services into the community.

Since 2005, Kentucky has transitioned approximately 64 individuals from ICF/MR's into the community. Community services are provided through the Supports for Community Living (SCL) Waiver. The state offers an enhanced rate to SCL providers who serve transitioning members. The enhanced rate of \$125,000 per member for the first two years after transition is intended to allow the provider sufficient funding to provide for the special needs of those transitioning from the institutional setting. Kentucky plans to use the experience gained from those transitions and the enhancements offered through the grant to enhance the current process.

In 2001, Kentucky developed a nursing facility transition pilot project funded by a Real Choice Systems Change Grant. *Kentucky Transitions*, the state's MFP Demonstration Project, seeks to address the barriers and close the system gaps identified during the nursing facility transition pilot project and the current ICF/MR transition process and address the unique challenges faced by individuals in rural areas. *Kentucky Transitions* seeks to achieve the following goals:

- **Rebalancing Goals:** Kentucky will increase the number of individuals receiving home and community based services. This will be achieved by the transition of 546 individuals from institutional settings into the community through the Kentucky Transitions Program.
- **Money Follows the Person/Flexible Budgeting Goals:** For each participant in *Kentucky Transitions*, the Kentucky Department for Medicaid Services will transfer a percentage of the annual cost of facility-based care to the home and community-based services (HCBS) Waiver programs. The current state budget process is fairly flexible and allows for the transfer of funds across budget categories as participants move from facility to community placements. Where the funding will be permanently will ultimately depend on where the participant is when they die or move. Under the budget process the funding will remain where the participant is or was at the time of budget forecast. If the participant is in a HCBS community placement at this time the funding will remain in HCBS services; however if the participant must move to a facility placement then the funding will move with the individual to facility services.
- **Continuity of Services Utilizing existing 1915(c) Waivers:** Kentucky's 1915(c) HCBS Waiver services will continue to be available to *Kentucky Transitions* participants after the demonstration ends. Kentucky has reviewed the current waiver service array and determined that most of the waivers contain adequate services to support the participants in the community after the demonstration ends. A gap was identified in the service array for the aged/disabled population. Kentucky will submit

one additional 1915(c) waiver to add nursing supports, residential and expanded homemaking, personal care, respite, etc. for those transitioning from or at immediate risk of entry to a nursing facility. Stakeholders participated in the development of the service array for this waiver. The waiver has been written and is being reviewed internally within the Department prior to submission to CMS. Kentucky is confident that the waiver will be submitted and approved prior to transition day 366. Currently, there are adequate slots in the existing waivers to allow for available slots at the end of the Demonstration Period. If it is determined that additional slots are needed, Kentucky will request those slots.

- **Transportation:** Kentucky will seek to eliminate the transportation issues encountered by waiver participants under the current Transportation Brokerage system. Kentucky convened a workgroup made up of consumers, advocates, and providers to explore the specific needs of waiver populations, including those in rural areas, which were not being adequately met under the current Transportation Brokerage system in Kentucky. During the demonstration period, participants will continue to pursue transportation to Medicaid covered services through the existing broker system. In addition, they will receive a monthly allotment to procure transportation services that are not available to them through the broker system (e.g., needing transportation outside the hours of operation), and to procure transportation to non-Medicaid covered services. They will have the flexibility to procure this service from friends, neighbors, and relatives, etc. This program will be piloted through *Kentucky Transitions* and monthly allotments will be tracked. Utilizing the results of this pilot program, Kentucky will explore adding transportation as service in the existing 1915(c) Waivers.
- **Housing:** Kentucky has contracted with the Kentucky Housing Corporation (KHC) to assist in the identification of and development of housing opportunities for those transitioning through *Kentucky Transitions*. This partnership has resulted in active involvement by KHC and other public housing entities in the development and implementation of *Kentucky Transitions*. The goal is to offer choice in housing to each participant who requires assistance by allowing them to participate in the decision making process, including indicating their preference of county and residence. Each participant will be given three housing option from which to choose.
- **Self Direction:** Kentucky currently offers Consumer Directed Option (CDO) through the existing 1915(c) Waivers. This also will be an option in the new waiver. CDO allows participants to hire family members, neighbors, etc. to provide their non-medical waiver services. The availability of CDO as an option allows participants choice of providers and an option if a traditional provider is not available.
- **Quality Assurance and Improvement:** Kentucky will expand its current quality management strategy to include frequent monitoring of transition participants during the demonstration period.

Kentucky plans to invest enhanced FMAP funds as follows:

- The enhanced FMAP funds will be used to fund additional slots in the 1915(c) waivers as needed to ensure availability of slots for transition. Slots will be available to participants to move into at day 366 but we also want to ensure that slots are

available to prevent institutionalization by providing necessary supports for members to remain in the community.

- We will use the enhanced funds to offer a transportation benefit in the MFP Demonstration service array that meets the particular transportation needs of waiver participants that are not currently being met by the transportation service defined in the State Plan. This service will be piloted as a demonstration service for Kentucky Transitions and the 1915(c) waivers will be amended to add this service.
- During the demonstration period, Kentucky will evaluate the utilization of new or expanded Medicaid services through the grant that are critical to support individuals in the community and prevent institutionalization/reinstitutionalization. This evaluation will lead to additions and expansions of waiver services.
- We also plan to utilize program savings to incorporate the services currently defined as Supplemental Services to meet the service needs of those transitioning after the demonstration ends.

Kentucky Transitions focuses on creating transition opportunities for three identified populations: residents of nursing facilities (both the elderly and the physically disabled), individuals with mental retardation and developmental disabilities, and individuals with acquired brain injuries, all of which shall have resided in an institution a minimum of six consecutive months.

The following case studies provide, from the perspective of *Kentucky Transitions* participants, a comprehensive description of the overall program and proposed transition process.

CASE STUDIES

TRANSITION FROM NURSING FACILITY TO HOME AND COMMUNITY BASED TRANSITION (HCBT) WAIVER

Lucy is a 77-year-old female from Winchester (Clark County), Kentucky. She is a widow with two adult children who also live in Clark County. In July, 2007, Lucy suffered a cerebral-vascular accident (CVA). She was treated in a hospital in Lexington, Kentucky, for approximately 10 days. At discharge, she was transferred to a nursing facility. Due to the lack of available nursing facility beds in her county, she was transferred into a facility in an adjoining county. The facility is approximately a one-hour drive from her home, making frequent visits from family and friends difficult.

Lucy meets Nursing Facility Level of Care and became Medicaid eligible based on the institutional criteria after the first thirty days in the facility.

Lucy has expressed the desire to leave the facility and move back into her own home, but both her son and daughter have families and full-time jobs and are unable to provide the supports she requires to live in the community.

In Kentucky, the Long-Term Care Ombudsman provides information and education about *Kentucky Transitions*, the Money Follows the Person Program. Following a presentation by the Ombudsman, Lucy approached him and indicated her desire to move back to the community. The Ombudsman provided Lucy with information on how *Kentucky Transitions* could assist her in receiving services and supports in her own home or a family member's home.

When Lucy expressed a high level of interest, the Ombudsman contacted the *Kentucky Transitions* State Transition Team, which is the single point of entry into the Kentucky Transitions Program. Members of the State Transition Team are employees of the Department for Medicaid Services (DMS) in Kentucky. The Team is made up of a Registered Nurse and a Social worker who oversee and coordinate the Regional Transition Teams. The State Transition Team also reviews and approves transition and monitoring plans and authorizes transition services.

In Kentucky, Regional Transition Teams (RTTs) provide the education, support, and transition assistance to those who choose to transition from nursing facilities into the community. RTTs also are comprised of a Registered Nurse and a Social Worker who have knowledge of providers and supports in their community. These Teams are employed by Kentucky DMS to provide this service as needed statewide.

The LTC Ombudsman assisted the Regional Transition Team in scheduling a meeting with Lucy to provide her with information on *Kentucky Transitions*. Prior to this initial meeting, utilizing the state eligibility system, the RTT determined that Lucy currently is eligible for and receiving benefits from the Kentucky Medicaid Program.

Although Lucy does not have a legal guardian and makes her own decisions, she did indicate that she would like for her children to participate in the meeting. During the meeting, the Team provided Lucy and her children with written information on Kentucky

Transitions. This included information on the transition process, the services and supports available during the demonstration year, how she would receive her services after the demonstration year (see Attachments 1-7), as well as her rights and responsibilities, including the right to remain in the facility or return to nursing facility placement if she chooses (see Attachment 8). They explained that this is a voluntary program and that Lucy can opt out at any point. The Team also discussed with her the risks with regard to meeting eligibility standards after the demonstration period, the potential for reduction of her services after the demonstration period, and the possibility of not being able to return to the same facility or the same bed if she returns to the facility. Lucy made the decision to begin the process. Lucy's children were supportive of her decision and indicated interest in providing support to Lucy during and after transition. The Regional Transition Team explained Lucy's rights with regard to informed consent and obtained her signature on the informed consent document (see Attachment 9). Lucy was provided with a copy of the signed form.

Lucy's Medicaid eligibility had already been established and review of information from facility records and her most recent MDS indicated that she had been in a facility for more than six consecutive months. The Regional Transition Team screens all potential Nursing Facility participants for eligibility for *Kentucky Transitions*. This is a preliminary screening done to determine the individual's acuity level in order to indicate whether the state has the resources available to provide for the care needs of the individual in the community. Due to the fairly low average Nursing Facility cost of \$34,500/resident/year, waiver services in the community cannot exceed that cost. If the screening indicates that the individual has a high level of clinical care needs that exceed the level of services available through the waivers and community services, the assessment process is ended and the individual is screened out of the process. The RTT utilizes information from the most recent MDS, conversations with the nursing facility staff and social worker, as well as interviews with Lucy herself to complete the *Kentucky Transitions* Screening Tool (see Attachments 10a and 10b). The results of the screening process indicated that Lucy was a potential participant for the transition process. Lucy was then assisted in completing the initial preferences assessment (See Attachment 11) which identified supports and services she believes she will need in the community.

Over the next week, the Regional Transition Team utilized the *Kentucky Transitions* Assessment Tool (see Attachment 13) to complete an in-depth assessment of Lucy's clinical and psychosocial support needs. The assessment is completed through observations of and interviews with Lucy, information from the most recent MDS, review of her medical chart, interviews with nursing facility staff, and Lucy's daughter and other family members.

The assessment provided information on Lucy's clinical, social, and support needs. The stroke had left her with residual left hemi-paresis. She experienced weakness and difficulty with balance but was able to ambulate with the assistance of a walker. Because of weakness in her left arm and hand, she had difficulty with some tasks but she could feed herself and prepare simple meals such as sandwiches and soup using

the microwave. She required assistance in preparing hot meals. She was able to shower using a shower chair but needed assistance getting in and out of the shower and washing her hair. She was able to dress herself but needed assistance with buttons and zippers and putting on her shoes. Lucy was on medication for hypertension and diabetes. She experienced short-term memory loss and required assistance in remembering to take her medications.

In the months since Lucy's admission to the nursing facility, she had lost her rental home and her children had moved her belongings into storage. She used to pay her own bills and manage her finances but since her admission to the facility, she no longer had a bank account. Lucy does not drive or own a car so she will need assistance with all her transportation needs including to grocery shopping, church, and other daily activities.

Lucy indicated that she would like for her daughter to participate in the Transition Planning process along with her. The RTT begins meeting with Lucy and her daughter to develop a transition plan that addresses her clinical and support needs and wishes. Because Lucy did not drive, she utilized the existing transportation broker system for transportation to Medicaid covered services. She also received a monthly transportation allotment to allow her to procure transportation to services occurring outside the broker hours of operation or not covered by the current broker system. Utilizing this allotment, Lucy was able to pay neighbors and family members to take her to the pharmacy, grocery, etc. Lucy also was presented with the concept of Consumer Directed Options (CDO). CDO would allow Lucy to hire, direct, and supervise friends and family members to provide her non-medical, non-residential services such as bathing, dressing, housework and meal preparation. Lucy indicated a desire to hire her niece to assist her with her personal care and homemaking needs. The Department for Medicaid Services provided Lucy with a budget for those services. Lucy was able to negotiate her own rates and make her own decisions on how and when those services are provided. Once her support system was identified, the RTT assisted Lucy in identifying the provider supports she needed. The RTT will assist Lucy in identifying and locating community providers.

The RN of the RTT reviewed Lucy's rehabilitation program at the nursing facility and met with Lucy and her therapists to identify her anticipated therapy needs in the community.

The Regional Transition Team assisted Lucy in developing an emergency back-up plan which indicated who would provide services if the primary service provider did not. Back-up plans were developed for each service Lucy would receive, including those she would self direct. Lucy was a fall risk and was provided a Personal Emergency Response System to activate in case of a fall. Family resources identified to provide back-up transportation services when needed. The RTT worked with Lucy and her daughter to ensure that the plan was very clear on who Lucy would contact when any service provider did not show up or when she had any kind of emergency. She was

instructed to contact the RTT anytime she the back-up plan was utilized and they would assist her in revising her back-up plan when needed.

The Transition Plan developed by Lucy and the RTT indicated that she needed the following services in order to live in the community:

- Personal care and homemaking for 6 hours a day, 7 days per week
- Nursing Supports (2 visits/week) for blood sugar and blood pressure checks
- Physical therapy (2 times/week) as a state plan service
- Adult Day Social (3 times/week), provided by the local Senior Citizen's Center
- Pharmacy Services as a state plan service
- Transportation Service provided by the State Transportation Brokerage system for transportation to Medicaid covered services. Lucy would also be provided with a monthly transportation allotment so that she could identify and pay providers including friends and family members to transport her to services not covered or provided by the Broker. The monthly allotment would be developed based on her projected transportation needs and evaluated and adjusted monthly.
- PERS – a Personal Emergency Response System would be purchased which would allow her to push a button to summon help.
- Medication Reminder – Lucy would purchase a Medication Reminder Machine, utilizing the Goods and Services Benefit. A nurse would be scheduled to load her medications into the machine once a week.
- Transition Services – it was determined that Lucy needed the following transition services which would be procured by voucher by the Social Worker on the RTT: a grab bar would be installed in the bath tub and a shower chair purchased; Lucy's furniture was in storage but her bed needed to be replaced; deposits would be made on the apartment and the utilities. The RTT Social Worker would assist her in opening a bank account and developing a monthly budget. Prior to the move, a one week supply of food would be purchased and stocked in her new residence.

Once the Transition Plan and a timeline for completing the pre-transition services was completed, the Regional Transition Team submitted it to the State Transition Team for approval. Once approved, the Regional Transition Team began assisting Lucy in implementing the plan.

The assessment indicated that in order to transition, Lucy would need assistance in obtaining housing. Kentucky contracts with the Kentucky Housing Corporation, which provides three Regional Housing Coordinators for the *Kentucky Transitions* program. These Regional Housing Coordinators are located in Eastern, Central, and Western Kentucky and have relationships with public and private housing entities and resources in their respective region of the state. When housing assistance is needed, the Housing Coordinator becomes part of the Regional Transition Team.

The Regional Housing Coordinator met with Lucy to review her housing needs and preferences and to evaluate her eligibility for housing subsidy. The Regional Housing

Coordinator obtained information from Lucy to complete the application and documentation process for a housing subsidy. Lucy's eligibility for a subsidy was based on her income, resources, and expenses. It was determined that she is eligible for a rental assistance subsidy. Lucy indicated that she would like to return to Clark County to be near her family. If she was unable to return to Clark County, she indicated that she would be willing to move to one of two adjoining counties in close proximity to her family. The Housing Coordinator began the process of identifying available housing in Clark County and two adjoining counties. Lucy indicated that she is interested in an apartment in the Heritage Retirement Center, a subsidized housing complex in Clark County. Unfortunately, the Heritage Retirement Center had a waiting list with no foreseeable openings for the next 6-7 months. The Regional Housing Coordinator identified three potential living placements for Lucy, however, there was no available housing in Clark County and the three choices were in the two adjoining counties. Arrangements were made with Lucy's daughter to pick her up and take her to see the available apartments. Because Lucy had already completed an application and was found eligible for a rental assistance subsidy, she was able to secure housing at the Bluegrass Retirement Community in an adjoining county, approximately 33 miles from her daughter's home. Lucy's daughter continued to be supportive and was willing assist with transportation as planned.

The team begins to work with Lucy to determine her provider preferences and schedule her services. She indicated that she would like to utilize Dr. John Smith, her previous physician, for her medical care needs once she returned to the community. The RTT RN assisted Lucy in contacting Dr. Smith's office to provide the needed medical records update and scheduled an appointment shortly after her move. Lucy chose the Bluegrass Home Health Agency to provide her nursing supports. An LPN was scheduled to visit Lucy twice a week on Tuesdays and Thursdays for blood sugar and blood pressure checks and to fill her Medication Dispenser once a week. The Main Street Pharmacy was contacted and arrangements were made to fill and deliver her prescriptions the day she moved to her apartment.

The Team assisted Lucy in setting up a meeting with her niece who would provide her personal care and homemaking services. Lucy was able to negotiate a rate with her niece to come to her house twice a day to assist her. She was scheduled to come in the morning to assist her with showering and dressing and to prepare breakfast each morning and a light lunch on the days Lucy did not go to Adult Day Services. Lucy's niece would also take care of housecleaning, laundry, and grocery shopping chores. Her niece would come again in the evening to prepare a hot meal and to assist Lucy in changing her clothes to get ready for bed. In the event her niece was unable to come, Lucy arranged for a family friend to come in her place. She also contacted Bluegrass Home Health Agency to provide those services in case of an emergency.

Lucy decided she would like to receive Social Adult Day Services at the local Senior Citizens Agency which will provide transportation to and from the center on Monday, Wednesdays and Fridays. She would receive therapy at the Adult Day Center.

The RTT Housing Coordinator and Social Worker assisted Lucy in leasing her apartment and paid the deposit. Lucy would move on the first of the next month. Arrangements were made to have the utilities put in her name on the first of the next month and utility deposits were made. A contractor was hired by the housing provider to install the grab bar in the bathtub.

The RTT Social Worker assisted Lucy and her daughter with several final details prior to her transition back from the nursing facility. Since Lucy had left the community, she had closed her checking account, hence Lucy and her daughter chose a bank and opened a checking account. A budget was established with the input of Lucy and assistance from the RTT Social Worker and Lucy's daughter. The RTT Social Worker then made arrangements to have telephone service installed in Lucy's apartment, while the RTT RN ordered the necessary durable medical equipment, including the shower chair, the PERS, and the medication reminder machine. The RTT also assisted Lucy in locating a new bed and made arrangements for the purchase and delivery. Arrangements were made to move her household furniture and personal items from storage, and Lucy's family unpacked her belongings. On the day prior to the move, the Regional Transition Team purchased food for Lucy's first week in the apartment.

Once all arrangements were made, the Regional Transition Team contacted Lucy's son and daughter who transported Lucy from the nursing facility to her new apartment. The entire transition process from initial assessment to the day of the move, took approximately seven weeks. After Lucy made the transition into her apartment, the Regional Transition Team contacted her weekly to ensure that she was receiving services as planned and to address any issues that may have occur post transition. Lucy's daily schedule was been filled with regularly scheduled visits by her niece, attending adult day, and even attending her local church. Lucy did, however, encounter a dilemma with transportation when she arrived for her doctor's appointment which began at 4:00pm. She realized the taxi provider's cut-off hours for Medicaid services ended at 5:00pm and she would not be finished in time to use the same provider. Hence, Lucy used her Transportation Allotment to contact a neighbor to provide her with a ride home.

During the next six months, the RTT contacted her weekly with one contact a month being on-site. The RTT monitored Lucy's care plan and made sure everything was working well. If a problem was encountered, the RTT assisted Lucy in amending the plan. Lucy contacted the RTT if she utilizes her back-up plan and the RTT assisted her in tracking the frequency of utilization of back-up services and any needed amendment to her care plan. During the fifth month post-transition, the RTT assisted Lucy in locating a Support Broker to assist her with her services. Support Brokers are local AAA agencies who provide that service in lieu of case management to people who choose to consumer direct. The RTT worked with the Support Broker to familiarize them with Lucy's care plan and her ongoing needs. At six months, primary case management was transitioned to the Support Broker. The RTT checked in monthly with Lucy to ensure that this transition went smoothly. Lucy received her services through the Demonstration Service Array for the first 365 days she was in the community. Two

months prior to the end of the Demonstration Period, an assessment to determine level of care for ongoing 1915(c) waiver eligibility was performed. This was to ensure an adequate amount of time to address problems/issues should Lucy not meet the level of care requirement to continue in the HCB Waiver program. At this time, Lucy was also given the opportunity to decide if she wished to continue to consumer direct her services through that waiver. Since CDO was working well for her, she chose to continue.

Kentucky plans to provide services to participants during the Demonstration period utilizing a Demonstration Service Array which includes existing 1915(c) Waiver services, expansions and additions to those services, and Supplemental Services. On day 366, participants will be moved into a slot in the appropriate 1915(c) Waiver. Lucy will receive services through the HCB Waiver which had no waiting list.

The RTTs will be responsible for administering the required Quality of Life Surveys in accordance with the protocol established and agreed upon by CMS and Mathematica.

TRANSITION FROM INTERMEDIATE CARE FACILITY TO SUPPORTS FOR COMMUNITY LIVING WAIVER

Clara is a 58 year old woman who was born in the Northern Kentucky area. Her parents became concerned when normal skills development did not occur. She was reportedly dropped on her head at three weeks of age by a cousin, and this was not known until sometime later in her life. Her parents became concerned when normal skill development did not occur. At the age of 9 months she was not sitting up, but did sit up at 1 year. She crept at 14 months and walked at age 3 and 1/2 years. Subsequent evaluations resulted in diagnoses of Cerebral Palsy and Mental Retardation. There was also some indication of possible Microcephaly.

Clara lived with her parents and grandparents until her admission to an Intermediate Care Facility in Somerset, Kentucky, on 7/29/1981. She was admitted as her parents believed they could no longer provide adequate care for her. Clara has two brothers and a sister. Clara lived in a facility that is approximately three hours from her home in Northern Kentucky. After her admission to the ICF, Clara's family was able to visit every 4 to 6 months. At the time of her transition, her mother had passed away and her sister had been appointed her legal guardian. Clara's father lived with her sister and brother-in-law.

When Clara's sister first became her legal guardian, she expressed an interest to Clara's treatment team at the ICF/MR in having her move closer to her family. Clara's sister was unable to have her move into her home as she was already providing care for their elderly father, but did want Clara closer to home. The treatment team provided her with information on *Kentucky Transitions*. After receiving the information, she requested further education on the program and was put in contract with the ICF/MR Transition Coordinator. The ICF/MR Transition Coordinator notified the *Kentucky Transitions* State Transition Team, which serves as the single point of entry into the program.

In Kentucky, the Federal Department of Justice has approved an ICF/MR transition process for all individuals transitioning from state-operated ICFs/MR. This process also is used for transition from private ICFs/MR. The ICF/MR Transition Coordinator is a Qualified Mental Retardation Professionals (QMRPs) employed by the Kentucky Department for Mental Health and Mental Retardation Services (DMHMRS) to facilitate all ICF/MR transitions. DMS is partnering through a contract with DMHMRS to educate and transition individuals through *Kentucky Transitions*.

The Transition Coordinator arranged a meeting with Clara and her sister at the facility to provide education and information on *Kentucky Transitions* and to answer their questions related to transition. The ICF/MR Transition Coordinator explained that *Kentucky Transitions* is a voluntary program and Clara and her sister, her legal guardian, were provided with written information about the complete transition process, services and supports available during the demonstration year and how those services will continue after the demonstration year (see Attachments 1-7), as well as her rights and responsibilities, including the right to remain in the facility or return to facility

placement if she chooses (see Attachment 8). Clara's sister chose to have Clara continue with transition. The Transition Coordinator explained her rights as a legal guardian with regard to informed consent and provided her with a copy of the informed consent document (see Attachment 9) which she signed.

Utilizing the state eligibility system, the Transition Coordinator determined that Clara is currently eligible for and receiving benefits through the Kentucky Medicaid Program. Information from facility records indicated that she had been in the facility for more than six consecutive months.

Over the next few weeks, Clara's transition team, which included the ICF/MR Transition Coordinator and facility staff, completed an in depth assessment of Clara's clinical and social support needs which included information from her most recent assessments by therapists, physicians, nurses, psychologists, and psychiatrists as well as interviews with ICF/MR staff and observation of and interviews with Clara. The assessment included obtaining information regarding her support needs and preferences.

Clara has the following DSM-IV Diagnoses:

Axis I: None

Axis II: 318.2 Profound Mental Retardation

Axis III: PICA, Cerebral Palsy (hand tremors), generalized tonic-clonic seizures, alternate exotropia, mild osteoporosis, constipation, Barrett's Esophagus (short segment), gastritis, and cataracts.

Clara's current Medical Treatment Plan at the ICF/MR addressed seizures, GERD, falls,, and skin integrity risks among other medical issues. Clara had been diagnosed with cataracts and was not responsive to visual acuity testing. She had a diagnosis of hyperopia with no glasses recommended.

At the ICF/MR, she required monitoring for unsteadiness when walking and at times used a gait belt. Clara ambulated independently in the home and across campus at the facility with some assistance from staff. In her residence, she frequently crawled. She was able to ambulate on even and uneven surfaces, but it was recommended that she have paved areas to walk to help prevent falls and subsequent injuries. She was able to ascend and descend stairs and required little assistance with transfers. She had good sitting balance and fair standing and walking balance. Handrails on stairs and in the bathroom were recommended for safety.

Her facility treatment team suggested purchasing a wheelchair for her to use after transition due to Clara's occasional refusal to walk. Her physical therapist was not in agreement and had concerns related to promoting unwarranted dependency on a wheelchair. The Transition Team agreed to have Clara re-assessed by a SCL certified physical therapy provider and, based on the two reports, come to consensus concerning the need for a wheelchair during the first 30 days following her move.

Clara required physical assistance to complete activities of daily living and was encouraged to participate as independently as possible in self-care. Clara required total physical assistance for bathing, hair care, nail care, dressing, and undressing. Clara does not go to the restroom independently.

Clara needs to have her medications administered to her. She needs encouragement to open her mouth and take medication. She does best when the medication is crushed and placed in applesauce or pudding.

Clara is a slow eater and needs plenty of time to finish her meal. She is edentulous and requires a high fiber, ground diet. She must remain in an upright position 45 minutes to an hour after eating. She receives no food after 8:00 p.m. and no bedtime snack. She uses a captain's chair, close to the table, with feet on the floor during all her meals. Clara uses the following adaptive equipment for eating: built-up handled coated infant spoon; dycem pad; nose cup; high-sided, sectioned dish; and captain's chair. Clara requires that someone be sitting at the table assisting her when she eats.

Clara needs assistance in arranging transportation. She requires assistance getting in and out of vehicles, as she may not want to step up or down due to the varying heights of different vehicles. She responds well to the use of a stool or lift. She also needs supervision due to inability to recognize safety hazards. She needs assistance to fasten seat belts. She tolerates the seat belt well, but on occasion unbuckles it.

Clara is nonverbal, but can express her wants and needs through body language, facial expressions, reaching for desired items, leading and natural gestures. She responds well to individual attention and praise. She recognizes emotions in others and expresses her own emotions. Clara responds to her name and makes eye contact. She is able to complete simple requests related to her daily routine with additional prompting.

At the ICF/MR, Clara's support staff gave her opportunities for making choices. They suggested talking with Clara about what activity she is performing and also naming objects that she is using. Clara spends the majority of her leisure time sitting in her recliner with a blanket. She also enjoys magazines, picnics, and parties. For her safety, Clara must be under supervision during all waking hours.

After the assessment was completed, the Transition Team provided Clara's sister with a list of potential providers, including residential providers. The Transition Team assisted them in making contact with and scheduling and facilitating visits to providers close to her family's home.

Clara and her sister were able to visit different residential options, including group homes, staffed residences, Adult Foster Care, and Family Home Providers. Clara's sister ultimately chose a staffed residence located in Independence, Kentucky, near her family home. As Clara is nonverbal, her feelings about the home were based on her facial expressions (smiling) and actions, such as taking her sister's hand and leading

her throughout the home. This was a 3 bedroom, 2 bath ranch-style residence. Clara would have her own room, while another client occupies the third bedroom. Clara also expressed that she liked the other client living in the home. Common areas of the home included a kitchen, dining area, living room, and utility room. There was a backyard for outdoor activities and a porch on the front of the home with rockers and a swing.

Clara and her sister also were provided with a list of and met with several case management providers. Clara's sister chose the case manager and agency with which she and Clara would work best.

Clara and her sister also visited various day program sites and types. These included Adult Day Training providers, Prevocational Training providers, and Supported Employment providers. Again, Clara's sister chose the provider, gauging Clara's interest and agreement based on her facial expressions and behaviors during these visits.

The same process was used for Clara and her guardian to choose physical therapy, occupational therapy, and speech therapy providers. In relation to a primary care physician and medical specialists, her guardian chose these providers based on her own knowledge of providers in the area. Based on the results of the assessment and utilizing the principles of person-centered planning, the regional transition team joined with Clara, her sister, and her team to develop a transition plan that addressed her personal goals as identified during the assessment process, clinical and support needs. This team facilitated by the Transition Coordinator was comprised of Clara, her sister, her brother-in-law, her current treatment team and her chosen community providers. Clara's identified preferences and dislikes were integral components of the planning for community supports. The Transition Team reviewed Clara's Individual Life Plan at the ICF/MR and identified supports needed by community service providers. Identified community service providers also included a primary care physician, needed specialists such as a neurologist and gastroenterologist, dentist, pharmacy and hospital. The transition plan was completed and included the *Kentucky Transitions* Plan, the Individual Life Plan, the Facility Medication Administration Record, and the Community Crisis Plan. Another integral element of the transition care plan was the identification of alternate supports; including agencies and individuals who can provide necessary supports and services for Clara should the usual provider not be able to do so. The plan was submitted to the State Transition Team for approval to begin implementation.

Cross training was completed between Clara's institutional providers and community providers. The training occurred at the ICF/MR and also at the various provider sites. The training included, but was not limited to, her dining plan, use of the gait belt, and personal preferences and supports needed for completion of personal care and other activities of daily living. Once this training had occurred, the facility staff scheduled and provided Clara with transportation to daytime and overnight visits to her new home. Medical appointments were made to occur within the first 30 days following the move and arrangements were made for medications to be available upon transition. All team members reviewed and approved the final transition plan. The State Transition Team authorized the existing waiver services, demonstration, and supplemental services

during the transition planning process and for the initial 365 days. The transition team then met for the final discharge meeting and a discharge date was established.

During the course of the initial 365 days under *Kentucky Transitions*, Clara was served by and had access to:

- The staff of the ICF/MR, including the Transition Coordinator
- SCL certified support providers who are monitored by The Department of Medicaid services through The Division of Mental Retardation. Clara received the following services through a certified provider as existing waiver services: Case Management, Staffed Residence, Adult Day Training, Occupational Therapy, Speech Therapy, and Physical Therapy
- The Regional and State Transition Teams
- DMR Regional Liaisons and Area Administrators

Supplemental services included construction of a ramp for accessibility and Community Provider Supports related to expenses of traveling to the ICF/MR.

In order to ensure successful transition to community life and the ability to remain in the community, the Department for Mental Health and Mental Retardation Services Facility Transition Practice requires a minimum of a 30 day, 60 day, 90 day, 6 month, and 12 month follow-up visit to Clara's chosen residence. These visits are made by the ICF/MR staff, DMR Area Administrators for the SCL program, and DMR Regional Liaisons for the ICF/MR Facilities. At this time, the current treatment plan, crisis plan, incident reports, and behavior support plan (if applicable) are reviewed. The visits also include discussion of progress and issues needing additional follow up or support from the ICF/MR to the community providers. Subsequently, issues are tracked by the ICF/MR team and the Transition Coordinator until resolution. The Transition Coordinator will track and report these issues to the State Transition Team based on the monitoring requirements under the grant.

Additionally, *Kentucky Transitions* requires that the Transition Coordinator make weekly contacts, with at least one on-site visit during the first six months after transition. The weekly contacts are made to ensure that Clara's transition plan is working and that no modifications need to be made. There are chart audits and visits to the day program during the on-site contact. During the last six months, the Regional Transition Team will make monthly visits to ensure that services continue throughout the 365 days after transition. The community case manager, the ICF/MR staff and the Regional Transition Team are available by telephone on a 24/7 basis for assistance

During the Demonstration period (the first 365 days following transition), Kentucky plans to provide services to individuals transitioning from facilities to the community through the Demonstration Service Array which includes existing 1915(c) waiver services, expansions, and additions to those services and Supplemental services. On

day 366, services will be provided through the Supports for Community Living Waiver, and Clara will be moved into a slot in that waiver. Assessment will take place at least two months prior to day 366 to ensure that Clara meets level of care and Medicaid financial eligibility.

The SCL case manager will be responsible for obtaining the Level of Care and service authorization prior to day 365. With a diagnosis of profound mental retardation, it is likely that Clara will continue to meet level of care. However, should she not, the Transition Team will work with her and her family to make every effort to find alternate funding sources, which may include the use of such sources as State General Funds through Kentucky's Regional Community Mental Health System and Hart Supported Living Grants.

After transition, Clara did experience some difficulty with behavior issues as related to obtaining a new level of comfort and trust in her new home and environment. Over the course of the first two to three months, Clara refused to cooperate on several instances with the housing staff and would not participate in community functions. A referral was made to the appropriate therapists for behavioral therapy to assist with readjustment issues and this proved successful.

Throughout the follow up process, Clara's transition team and caregivers reported many advantages stemming from her move to the community. Because she was able to return to the Northern Kentucky area and was in close proximity to her family, visits increased to at least once weekly. Reconnecting with extended family members and participating in more leisure activities became a part of Clara's daily schedule.

The RTTs will be responsible for administering the required Quality of Life Surveys in accordance with the protocol established and agreed upon by CMS and Mathematica.

TRANSITION FROM BRAIN INJURY SKILLED NURSING FACILITY TO ACQUIRED BRAIN INJURY (ABI) WAIVER

Dale is a 59-year-old male from Crestview Hills, Kentucky. At the time of his brain injury, Dale was married with two young children living in the home. He also has two adult children from a previous marriage. His mother is living and father is deceased. He was an Architect by trade and owned his own home. Health history was significant for alcohol abuse, with no other significant health issues reported.

On October 16, 2002, at age 54, Dale was found unconscious in the driveway of his home. As reported by his family, he had last been seen at 9:00pm the previous night. He had obviously fallen, but the cause of this fall is unknown.

Dale was transported to a local hospital and noted to have sustained bitemporal contusions, left subdural hematoma and subarachnoid bleeding. Dale transitioned from the initial hospital setting to a convalescent center setting then to a rehabilitation hospital setting. He made a slow gradual physical and cognitive recovery. However significant behavior problems were present in the form of agitation, unpredictability and impulsivity. On 12/09/03, Dale was transferred to a state owned Brain Injury Skilled Nursing Facility.

During the first month of service at this transitional living program, Dale received 24 hours per day of one-on-one Life Skills Training. He remained at Rancho Level V (Confused/Non-Agitated) and remained in post-traumatic amnesia. Slight improvement was noted in his cognitive functioning. During this time Dale was seen for occupational therapy services on a daily basis. He presented with generalized confusion with tangential speech and short attention span. He was highly agitated when confronted with competing environmental stimuli and suffered severe cognitive disorganization and an intolerance for processing information from more complex situations.

Due to Dale's lack of progress, therapists requested further medical tests be ordered. Testing subsequently revealed hydrocephalus and Dale was taken to surgery for stint placement. After stint placement, Dale's cognitive abilities were much improved. He became much more consciously aware of his surroundings and his agitation subsided. He was now able to fully participate in his rehabilitation services and significant progress was noted.

During Dale's hospitalization and subsequent Nursing Facility stay, his family's financial resources were depleted. During the nine months that Dale was at the facility, his wife divorced him, sold their home, and moved out of state with their two young children. His two older children had disassociated themselves from Dale and offered no support. His only potential community support was his elderly mother who could not manage Dale's needs alone.

After significant improvement in Dale's cognitive abilities and overall medical situation, he expressed the desire to leave the facility and return to his home. Due to his desire to leave the facility, his treatment team contacted the *Kentucky Transitions* State Transition Team which is the single point of entry into *Kentucky Transitions*. Members of the State Transition Team are employees of the Department for Medicaid Services (DMS) in Kentucky. The team is comprised of a Registered Nurse and a Social Worker who oversee and coordinate the Regional Transition Teams (RTT). The State Transition Team also reviews and approves transition and monitoring plans and authorizes transition services

In Kentucky, RTTs provide the education, support, and transition assistance to those who choose to transition from nursing facilities into the community. RTTs are also comprised of a Registered Nurse and Social Worker who have knowledge of providers and supports in their community. These teams are employed by Kentucky DMS to provide this service as needed statewide.

Dale meets nursing facility level of care and is eligible for and receiving benefits through Medicaid. The RTT set up a meeting with Dale to explain the *Kentucky Transitions* Program and how the services available might help him transition back to and remain in the community. The RTT met with Dale and his mother to provide them with information on the supports and services available to Dale through the *Kentucky Transitions* Program. It was explained that this is a voluntary program. They were provided with written information about the complete transition process, services and supports available during the demonstration year and how those services would continue after the demonstration year (see Attachments 1-9), as well as his rights and responsibilities, including the right to remain in the facility or return to the facility if he chooses (see Attachment 10). Dale indicated his desire to begin the process. Dale's mother was supportive of his decision and indicated interest in providing as much support as she was able. The Regional Transition Team explained his rights with regard to informed consent and provided him with a copy of the informed consent document (See Attachment 9), which he signed.

Utilizing the state eligibility system, the Regional Transition Team verified that Dale was currently eligible for and receiving benefits through the Kentucky Medicaid Program. Information from facility records and his most recent MDS indicated that he had been in the facility for more than six consecutive months.

Over the next week, the Regional Transition Team utilized the *Kentucky Transitions* Assessment Tool (see Attachment 12) to complete an in-depth assessment of Dale's clinical and social support needs, including interviews with nursing facility staff, and observations of and interviews with Dale. Dale's housing needs and preferences and information needed to determine his eligibility for housing assistance was also obtained.

Utilizing the results of the assessment and the principles of person-centered planning, the RTT began working with Dale to develop a transition plan that addressed his clinical and support needs. The RTT reviewed Dale's rehabilitation program at the nursing home and met with him and his therapists to identify his therapy needs in the

community. His mother identified what supports and back up she would be able to provide and other available resources to support him in the community. This allowed the RTT to identify the supports he will need from service providers.

At this time, Dale was presented with the concept of Consumer Directed Options (CDO), which would allow Dale to hire, direct, and supervise friends and family members to provide non-medical, non-residential services. The RTT explained the CDO option in detail and offered Dale the choice of directing his own services or accessing services through traditional providers. While Dale felt the CDO process may work for him at some point, he opted to receive his services through traditional service providers until he is established in the community. He was given information on how to initiate this process in the future through either the RTT or the local CDO Support Broker.

As part of the Transition Planning process, the RTT coordinates with Dale and his mother to develop an emergency back-up plan for Dale in the event that a critical service provider cannot provide services. Dale and his caregivers are instructed by the RTT about emergency back-up care and are involved in creating Dale's emergency plan (see Attachment 25 – Individualized Emergency Plan). Dale's plan includes the names and telephone numbers of persons to contact should his caregiver fail to report as scheduled. Dale's individualized emergency plan will be placed in his home and contains the names and phone numbers of his care manager, physician, and pharmacy. Emergency phone numbers are also posted for fire, abuse, ambulance, police, and poison control.

Dale's plan indicates that he needs the following services in order to live in the community:

- Home and Community Supports (personal care and homemaking services) 4 hours a day, 7 days a week
- Structured Day Services 5 days per week 4 hours per day
- Occupational Therapy 5 days per week for 2 hours each day
- Speech Therapy Services 3 days per week for 1 ½ hours each day
- Transportation Services to medical and therapy appointments
- Companion services 5 days per week for 2 hours each day
- PERS – a Personal Emergency Response System will be purchased which will allow him to push a button to summon help
- Transition Services – it has been determined that Dale will need the following transition services: a grab bar will need to be installed in the bath tub and a shower chair will be purchased; Dale's furniture is in storage but his bed will need to be replaced; deposits will be made on the apartment and the utilities

Once his transition plan was completed, along with a timeline for completing the pre-transition services, the RTT submitted it to the State Transition Team for approval. Once approved, the RTT began implementing the plan.

Upon receipt of referral from the RTT, the Regional Housing Coordinator began working to locate accessible, affordable integrated housing for Dale based on his needs and preferences. The Regional Housing Coordinator determined that Dale is eligible for subsidized housing. The Housing Coordinator identified three potential residential options for Dale, one in his county of preference and two in an adjoining county. The transition team made arrangements for Dale to travel to view the housing options. Dale chose an apartment in Parkview Hills, a subsidized housing complex in Crestview Hills. This is a one bedroom apartment with a living room, kitchen and bathroom. Dale will have a twelve month lease with an escape clause. This public housing complex is a waiver provider under the ABI Transition Waiver and is available to provide the Home and Community Supports service to its residents, if selected.

Dale indicated that he would like to return to his community provider, Dr. Tom Brown, as his physician. The RTT RN contacted Dr. Brown's office to arrange for the transfer of medical records and to set up an initial appointment with Dr. Brown. Dale chose to receive his personal care and homemaking services through his housing provider. Occupational and Physical Therapy visits were scheduled through Active Therapy. The Main Street Pharmacy was contacted and arrangements were made to fill and deliver his prescriptions the day he moved to his apartment. The RTT Housing Coordinator and Social Worker assisted Dale in leasing his apartment and paid the deposit. Dale will move on the first of the next month. Utilities deposits were made. The RTT Social Worker arranged for the purchase and installation of grab bars for his bathroom to assist with safe transfer in and out of the tub/shower. As Dale's short-term memory has been affected by his brain injury, he has also received a planning book to aid with organization and cueing for his activities of daily living. A medication reminder watch has also been purchased to aid Dale in administering his own medications. Since Dale has left the community, he has closed his checking account. The RTT Social Worker assisted Dale in choosing a bank, opening a checking account, and creating a budget. Arrangements were made to have telephone service installed in the apartment so that he will be able to contact family and friends. The RTT Nurse purchased equipment, including a shower chair, the PERS, and a bed, and arranged for delivery. Arrangements were made for a van to transport Dale and his belongings to his new home. On the day prior to the move, the RTT purchased food that Dale could prepare easily for his first week in the apartment.

The RTT will make weekly contact with Dale during the first six months in the community, with at least one monthly on-site contact. The team will monitor Dale's plan and make sure that everything is working well. If a problem is encountered, the team will assist Dale in amending the plan. Dale will contact the team if he utilizes his back-up plan, and the team will assist him in tracking the frequency of utilization of back-up services and any needed amendments to his care plan. During the fifth month after transition, the team will assist Dale in locating a case manager to assist him with services. The RTT will work with the case manager to familiarize them with Dale's care plan and his ongoing needs. Case management will be transitioned to an independent case manager of Dale's choice at six months post transition. The Transition Team will

continue to monitor Dale's placement and make monthly visits during the following six months.

Dale will receive his services through the Demonstration Service Array for the first 365 days post transition. At least two months prior to the end of the Demonstration Period, an assessment to determine level of care for ongoing 1915(c) waiver eligibility will be performed. This will ensure an adequate amount of time to address problems/issues should Dale not meet the level of care required to continue in the Acquired Brain Injury (ABI) Long-Term Waiver program.

Kentucky plans to provide services to participants during the Demonstration Period utilizing a Demonstration Service Array which includes existing 1915(c) Waiver services, expansions and additions to those services, and Supplemental Services. On day 366, participants will be moved into a slot in the appropriate 1915(c) Waiver. Dale will receive services through the ABI Long-Term Waiver program which has no waiting list.

The RTTs will be responsible for administering the required Quality of Life Surveys in accordance with the protocol established and agreed upon by CMS and Mathematica.

BENCHMARKS

Kentucky Transitions proposes the following five (5) benchmarks, the first two of which are required by all awardees.

Required Benchmark #1: The projected number of eligible individuals in each target group of eligible individuals to be assisted in transitioning from an inpatient facility to a qualified residence during each fiscal year of *Kentucky Transitions*.

TARGET POPULATION	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
Individuals who are elderly	11	78	78	48	215
Individuals who are physically disabled	1	33	34	22	90
Individuals with MR/DD	8	72	72	45	197
Individuals with ABI	2	17	17	8	44
TOTAL	22	200	201	123	546

Required Benchmark #2: Qualified expenditures for HCBS during each year of *Kentucky Transitions* by target population.

TARGET POPULATION	Baseline SFY06	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
Individuals who are elderly and/or physically disabled	\$ 93,982,536	\$104,206,338	\$115,017,917	\$123,448,083	\$130,958,488	\$473,630,825
Individuals with MR/DD	\$177,876,388	\$196,836,672	\$224,532,032	\$244,162,.104	\$260,612,347	\$926,143,156
Individuals with ABI	\$ -	\$ 105,937	\$ 1,612,891	\$ 2,394,309	\$ 2,697,977	\$ 6,811,113
TOTAL	\$271,858,924	\$301,148,947	\$341,162,840	\$370,004,496	\$394,268,812	\$1,406,585,095

Benchmark #3: Percentage increase in HCBS versus institutional long-term care expenditures under Medicaid for each year of *Kentucky Transitions*.

In Community Growth

TARGET POPULATION	Institutional Baseline SFY06	HCB SFY06	HCB as % of Baseline	SFY09	SFY10	SFY11	SFY2012
Nursing Facility	\$781,375,554	\$93,982,536	12.0%	13.3%	14.7%	15.8%	16.8%
ICF/MR	\$119,386,405	\$177,876,388	149.0%	164.9%	188.1%	204.5%	218.3%
ABI	\$ 7,415,021	\$ -	0.0%	1.4%	21.8%	32.3%	36.4%
TOTAL	\$908,176,980	\$271,858,924	29.9%	33.2%	37.6%	40.7%	43.4%

*Kentucky has recently implemented a new MMIS under a new contractor and we are still experiencing issues with the validity of some of the data. This is an issue we are working with continuously with our contractor. We were able to run the baseline for 2006 but we are still working on the 2007 data. We attempted to run the data again recently and were not comfortable with the validity of the data we received. We will continue working with our contractor and should have correct data within the next year. At the point we feel we have the valid baseline, we will send it immediately.

Benchmark #4: Increase in the availability of self-directed services (i.e., progress directed by Kentucky to expand opportunities for Medicaid eligible persons beyond those in *Kentucky Transitions* to either directly, or through representation, to express preferences and desires to self-direct their services and supports).

AVAILABILITY OF SELF-DIRECTED SERVICES	Baseline *	YEAR 2	YEAR 3	YEAR 4	YEAR 5
	550	55 (10% increase over baseline)	61 (10% increase over Year 2)	67 (10% increase over Year 3)	73 (10% increase over Year 4)
Total Number Self-Directing		550+55=605	605+61=666	666+67=733	733+73=806

*Individuals currently self directing in Kentucky Medicaid Waivers

Benchmark #5: Increase the availability and accessibility of transportation services to demonstration participants and increase the positive response rate between pre/post Quality of Life survey questions related to transportation (#28, #33, #34, #35, #36, &

#37). *Kentucky Transitions* intends to pilot a new approach for transportation services by issuing a monthly cash allotment for transportation services that can be self-directed by the demonstration participant upon transition into the community and that will expand into non-medical transportation needs in addition to medically related transportation needs currently provided by Transportation Brokers. This flexibility will also allow for transportation beyond the typical business hours as well as the typical workweek of the Transportation Brokers thereby being available for evening hours and weekends. As the infrastructure for transportation services expands to meet the flexibility demands, the level of satisfaction from pre/post is also expected to increase. Additional benchmarks may be established as the allotment process is defined. Based on the success of this approach, Kentucky will amend existing 1915 (c) waivers to add transportation as a waiver benefit.

TARGET POPULATION	Baseline	Year 2	Year 3	Year 4	Year 5
Individuals who are elderly and/or physically disabled, with MR/DD, or with ABI who receive a transportation allotment	0*	22	108	110	72
Increase is positive response rate for each question related to transportation in the Quality of Life survey	-	(Baseline)**	10%	20%	20%

*This is a new process for providing transportation service in Kentucky that will initially only be made available to demonstration participants.

**Only pre demonstration (baseline) data will be available from participants who transition out of the institutional placement will be available during Year 2.

II. DEMONSTRATION POLICIES AND PROCEDURES

PARTICIPANT RECRUITMENT AND ENROLLMENT

Kentucky Transitions is designed to create transition opportunities for three identified populations: the elderly and physically disabled, individuals with mental retardation and developmental disabilities, and individuals with acquired brain injuries, all of which shall have resided in an institution a minimum of six consecutive months. Transitioning of all three populations will begin in Year Two of the grant (CY2008) contingent upon receipt of CMS approval of the Operational Protocol.

Kentucky Transitions is a statewide initiative and involves nursing facilities and ICFs/MR. According to the CMS OSCAR Data Current Surveys (June 2006), there are 294 nursing facilities in the state in which 23,286 individuals reside. About 67% of these individuals are Medicaid members. Of those in a nursing facility, it is estimated that approximately 10% are individuals with a brain injury. As of October 2005, there were 13 Intermediate Care Facilities for Individuals with Mental Retardation or a Developmental Disability (ICFs/MR/DD) in Kentucky, housing 775 individuals of which 99% are Medicaid members. It is estimated that about 14% of these individuals have a brain injury. All of these facilities are existing Medicaid institutional providers and meet the statutory requirements of an eligible institution per 907KAR1:022.

The six month minimum residency period in an institutional setting will be verified by the MFP Transition Staff through medical records review, review of MDS, and interview with facility staff. Likewise, MFP Transition Staff are responsible for determining whether the transition participant has, as a minimum, been eligible for and receiving Medicaid services in the month prior to transition. This verification will be done utilizing access to the Medicaid Eligibility system.

ICF/MR Transition

Kentucky currently has an ICF/MR Transition Program in place for all ICF/MR's in the state. It should be noted that ICFs/MR/DD currently utilizes a transition process approved by the Federal Department of Justice for transitions from all state ICFs/MR. (See Attachment 14) This process is in place for individuals or legal guardians who indicate a desire to transition. ICF/MR Transition Coordinators employed by the Department for Mental Health/Mental Retardation (DMH/MR) coordinate transitions in the existing process. DMS will contract with DMH/MR to utilize the existing ICF/MR Transition Coordinators to do MFP outreach and education and facilitate MFP ICF/MR transitions. This process has been in place since 2005 and has transitioned approximately 64 individuals from ICFs/MR to the community utilizing services provided through the Supports for Community Living (SCL) Waiver. Kentucky offers an enhanced rate to SCL providers who provide services to individuals transitioning from ICF/MR's in the state. This rate is \$125,000 per individual per year for two years. The rate is an all-inclusive rate and is intended to fund the services and supports needed by an individual transitioning from the institutional setting into the community. Kentucky has determined that utilizing this existing process and ICF/MR Transition Coordinators and providing enhancements to that process through the MFP grant will best serve the needs of those wishing to transition without duplicating services. The role of the Kentucky Transitions Program in this existing process will be to assist in identifying and resolving barriers to transition that may currently exist in the ICF/MR Transition Process.

This will ensure that the enhancements and monitoring offered through the Kentucky Transitions Program are available to this population and to support the transition of these individuals into the community. Outreach to and education of ICF/MR participants and legal guardians related to Kentucky Transitions will be provided by the ICF/MR Transition Coordinators.

NF Transition

Kentucky does not currently have an infrastructure in place for the transition of Nursing Facility residents back into the Community. Kentucky Transitions will provide this infrastructure as well as all transition services and supports from education and identification through transition.

In addition to a public awareness campaign, specific outreach and recruitment activities will be undertaken to identify individuals residing in nursing facilities who may have an interest in transitioning to the community. The Kentucky Long-Term Care Ombudsman Office will provide outreach and information to potential transition participants. Additionally, *Kentucky Transitions* staff, Protection and Advocacy, and other provider and advocacy organizations will assist in outreach and recruitment activities (see Outreach, Marketing, and Education section of Operational Protocol). Outreach and marketing materials are provided to assist in these endeavors, including materials in accessible formats. If outreach and recruitment is not effective in identifying adequate numbers for transition in Year 2, beginning in Year 3 Kentucky will utilize MDS data to identify potential transition candidates and target outreach to those individuals.

Upon determination of an expressed interest by the individual or legal guardian in transitioning, the *Kentucky Transitions* State Transition Team, serving as the single-point of entry, will be contacted. This initial contact may come from the Long Term Care Ombudsman, a community agency, family members, guardians, facility residents, or others. The Regional Transition Team is notified of the individual's interest in transition. Prior to visiting with the potential transition participant, family members, guardians, and significant others, the Regional Transition Team notifies a designated contact person at the respective nursing facility that the individual has expressed an interest in transition. This notification is conducted as a professional courtesy to facilitate entry and access to facility residents by Regional Transition Teams.

The Regional Transition Team then meets with the potential transition participant, family members, guardian, and significant others to provide a comprehensive overview of *Kentucky Transitions*, answer questions, and address concerns. This guided discussion is educational in nature and is intended to assist individuals in making an informed decision about transition. Regional Transition Teams will receive training in how to conduct these guided conversations and be provided with conversation guidelines to ensure that all relevant areas are addressed. If the individual remains interested in transition, the Regional Transition Team prepares for the screening process by conducting a chart review, interviewing facility staff, and the potential transition participant, family members, guardian, and significant others. The *Kentucky Transitions* Screening Tool (see Attachments 10a and 10b) is designed to determine the

participant's acuity level to determine if the level of services the participant needs are available in the community. Screening results are based on interviews with the participant and facility staff, information from the resident's chart, and a review of the most recent MDS.

The *Kentucky Transitions* Assessment Tool (see Attachment 12) is designed to comprehensively assess participant transition needs across several life domains, including reasons for entering the facility; medical conditions and professional care; functional conditions and personal care; assistive technology; instrumental activities of daily living; housing; financial and legal; employment; vocational/educational; community services and supports; and family, informal, and social supports. This assessment will be completed by the Regional Transition Team. The results of this assessment are used in working with the participant or legal guardian as well as anyone else they choose to assist them in the development of an individualized transition care plan utilizing the person-centered planning process (see Consumer Supports section of Operation Protocol).

The participant or legal guardian and other designated team members assist in the Implementation of the approved transition plan. The participant or legal guardian participates in the identification of service needs, choice of service providers and whether they choose to consumer direct. Monitoring of the implementation of individualized transition care plan is the responsibility of the Regional Transition Team. The Team will monitor the individual in the community weekly during the first six months (with at least one visit per month being face-to-face). At 6 months, case management will be provided by the independent case manager of the participant's choice or to a CDO Support Broker, if the participant has chosen CDO. The Regional Transition Team continues to monitor plan implementation throughout the duration of the grant (see Quality Management section of Operational Protocol).

Reenrollment in Kentucky Transitions

Should a transition participant be readmitted to an institution or hospital for medical reasons, re-enrollment in *Kentucky Transitions* is possible. Re-enrollment, however, is contingent upon a comprehensive assessment of the reasons for re-institutionalization. Based on this reassessment, a review of the transition plan is conducted and appropriate services and supports are incorporated into the transition care plan. Reasons for re-institutionalization will be tracked through the Quality Management System.

INFORMED CONSENT AND GUARDIANSHIP

The informed consent procedures developed for *Kentucky Transitions* were developed collaboratively by consumers and family members, providers, and demonstration project staff. Upon expressed interest in participation in *Kentucky Transitions*, a determination is made as to whether the potential participant is a minor, if he is an adult, or if he is an adjudicated adult with a guardian. The Regional Transition Team obtains a copy of the legal document(s) and reviews them to gain an understanding of the extent of the surrogate decision-making power. The participant and the parent or guardian are involved in all aspects of information sharing, educational sessions, and decision-making processes to ensure that all participants and the parents and guardians are fully aware of all aspects of the transition process, have full knowledge of the services and supports provided both during the demonstration year and after, are fully informed of their rights and responsibilities as a participant, and that participation is strictly voluntary (see Attachment 14). In situations in which a guardian is involved, informed consent from the guardian is a prerequisite to participation.

An informed consent stating that the professional has explained all the information and procedure to the participant and/or guardian is required. For purposes of participation in *Kentucky Transitions*, the Regional Transition Team is responsible for ensuring that all the information and procedure has been included in the educational sessions and acquiring a signed and dated informed consent form from the participant/guardian. Kentucky Transitions will adhere to Kentucky State laws that are applicable to informed consent and guardianship. In Kentucky, an individual is a minor until age 18 (KRS 2.015), and a parent must give informed consent. An Adult is presumed to be competent to give informed consent, except if he has been adjudicated incompetent by a district court. The district court appoints a guardian who has the powers and responsibilities of a parent regarding support, care, education and consent to medical or other professional care. (KRS 387.065)

In Kentucky, only the individual may give consent or authorization for services unless the individual is a minor and is living with his/her parent or legal guardian. When parental rights have been terminated, the minor who is not in the custody of a legal guardian becomes a ward of the Cabinet for Health and Family Services, and a Cabinet representative must give consent for services. The individual can extend his dependency until age 21. If services involving surgery or the like are envisaged, the Cabinet representative gets an order from the district court. A Minor is emancipated at the age of 21 if the minor is disabled for the purpose of care and treatment. (KRS 2.015)

Emancipation occurs either by achieving age 18 or parents have relinquished custody and control. Carricato v. Carricato (1964). A person is deemed emancipated within the 1964 definition if he is self-supporting, married, has borne a child (in some cases), or is a member of the U.S. Armed Forces and is a recipient/applicant for Title V services under the Social Security Act. (KRS 205.710 (4))

The following are exceptions for consent by parent or guardian for a minor:

A patient is 16 or 17 and seeks mental health counseling. (KRS 214.185 0

A patient seeks diagnostic and treatment services for venereal diseases, pregnancy and chemical abuse. (KRS 214.185)

A patient who is married or borne a child who seeks services for self or child.

A patient who is a victim of a sexual offense. (KRS 216B.400)

A patient who, in the professional's judgment, needs medical treatment without delay. (KRS 214.185) For example, if the individual is in the midst of a procedure and unconscious or otherwise incapable of giving informed consent.

In Kentucky, an adult is presumed to be his or her own guardian. Only the State District Court can establish or revoke guardianship. The court process is governed by KRS 387.500 et.seq. The statute does not set minimum visitation requirements as a condition for continued guardianship. However, the statute requires an annual report, outlining the status of the ward's mental, physical, and social condition and the guardian's visits and activities on behalf of the ward. (KRS 387.670) The provider of services and supports shall provide for the guardian or LAR timely notification and toll-free telephone access for all planned meetings regarding the participant. Providers of services and supports shall be required to implement or cause to be implemented face-to-face visits between the guardian and the participant when the guardian is unable to travel.

The level of guardianship involvement in the six months preceding enrollment in *Kentucky Transitions* will be determined through conversations with facility staff, a review of the annual guardian report, the potential *Kentucky Transitions* participant, and the guardian. *Kentucky Transitions* staff will document both the relationship that exists between the guardian and the potential participant and the frequency of interaction with the potential participant throughout the entire transition process. It will be explained that active guardian participation and cooperation with the transition process is imperative. If the guardian is unable to travel to the educational sessions, he will be expected to participate through telephone or electronic correspondence.

The District Court has exclusive jurisdiction over all proceedings regarding the determination of disability and the appointment and removal of guardians through a hearing process. (KRS 387.520) Any competent person who agrees to serve as a guardian may be appointed to do so. The court takes into account the individual's preference. In order to avoid potential conflicts of interest, agencies, institutions, and Commonwealth of Kentucky vendors (including their employees, officers, directors, partners, and their families) providing care and custody to an incapacitated individual are prohibited from becoming his/her guardian. In instances in which an individual is deemed to be in need of guardianship but no suitable individual is willing to petition the Court, the Court may appoint a "state guardian" as provided by KRS 209.020. State guardianship in Kentucky is provided through The Cabinet for Health and Family Services (CHFS), Adult Protective Services. The Kentucky Department for Protection and Advocacy (DPA) has agreed to provide guardianship counseling to individuals or families who seek such assistance. The DPA has available upon request a publication entitled "Guardianship in Kentucky: A Guide for Citizens with Disabilities".

OUTREACH, MARKETING, & EDUCATION

More than a grant or program, *Kentucky Transitions* is a systematic change that allows flexible financing for long-term services and supports. This market-based approach gives participants more choice over the location and type of services they receive as their needs and preferences change. *Kentucky Transitions* also incorporates the philosophy of self-direction and individual control in state policies and programs.

The *Kentucky Transitions* Outreach/Marketing/Education Plan synthesizes information about the project and statewide options and distributes them through multiple media, educational, and marketing sources. This plan sees Outreach as directed to consumers, Marketing directed to providers, and Education directed to the general population of the Commonwealth. Proposed Outreach/Marketing/Education materials are attached in the Appendix (see Attachments 1-7). Other materials, letters and trainings are still being developed. Once finalized, all materials, including training materials, will be submitted to the CMS MFP Project Officer for final approval.

Public Awareness

Effective marketing and education are needed to raise awareness among consumers, family members, guardians, stakeholders, service providers, and the general public about this new service option. Having a high level of community awareness will assist in the identification of facility residents who may choose to return to the community.

Upon CMS approval of the operational protocol, Kentucky will begin implementation of a statewide public awareness campaign to increase awareness of home and community based resources geared toward independent living. The public awareness campaign will utilize the Area Agencies on Aging and Independent Living (AAA's), the ARC of Kentucky, the Centers for Independent Living (CILs), and the Brain Injury Association of Kentucky (BIAK) to conduct a minimum of three informational sessions in each of the state's 15 Area Development Districts during the first 90 days of implementation. The presentations will describe services available through Kentucky Transitions. The blitz will be followed by on-going sessions integrated with trainings and workshops already provided by each entity. In addition, the Department for Aging and Independent Living (DAIL) and the AAA's will provide education on Kentucky Transitions through the Kentucky Resource Market. The Market affords individuals seeking more information the ability to make one call at either the state or local level to access individualized assistance and options counseling.

Information about *Kentucky Transitions* will be located on the Cabinet for Health and Family Services, Department for Medicaid Services, Department for Mental Health and Mental Retardation, and Department for Aging and Independent Living, Kentucky Resource Market, and Area Agencies on Aging and Independent Living websites. The state will request other entities such as Protection and Advocacy, AARP, CIL, BIAK, ARC of Kentucky, and Kentucky Assistive Technology Services Network to include links or information to their web sites.

Outreach

Kentucky will utilize the Kentucky Long-Term Care Ombudsman's Office and the ICF/MR Transition Coordinators, as well as Protection and Advocacy, CILs, and other advocacy organizations to identify individuals residing in a nursing facility or ICFs/MR who may have an interest in transitioning to the community. Facility residents, family members, guardians and facility staff will be oriented to the eligibility criteria and provided with pamphlets and *Kentucky Transitions* contact information. The Commission on Deaf and Hard of Hearing, Kentucky Department for the Blind, the Department for Assistive Technology, and other state and local agencies will be utilized to provide services necessary to accommodate individuals with special needs to ensure access to information and materials

In addition, within 60 days of approval of the operational protocol, the MFP Team will begin a two month phased mailing process to send a letter to every Medicaid-eligible resident of a nursing facility or ICF/MR or their legal guardian describing *Kentucky Transitions* and the option to leave the facility and live in the community, if they choose to do so. The letter will provide information on the Kentucky Transitions Program, eligibility requirements, and contact information. Letters will be mailed initially to residents of the state ICFs/MR and approximately ¼ of the nursing facilities in the state. Letters will then be sent to the remaining residents of nursing facilities and the private ICF/MR every two weeks thereafter. If an individual is interested in further exploring the *Kentucky Transitions* option, they will be directed to contact the LTC Ombudsman, ICF/MR Transition Coordinators, the MFP Team or a Regional Transition Team. Kentucky will do the initial blanket mailings and then mail annually thereafter to potential applicants who have entered facilities in the interim. Kentucky will not rely on mailing alone to disseminate information on the program. The mailing is a formal notification of program availability. The Long Term Care Ombudsman and the ICF/MR Transition Coordinators will be doing ongoing and continuing outreach and education on Kentucky Transitions at facilities. Presentations to and dissemination of information through community agencies and advocacy groups will occur on an ongoing basis. Kentucky has designated a staff person to coordinate outreach and program education. All information provided to consumers and other stakeholders will emphasize that *Kentucky Transitions* is about personal choice.

Marketing

Kentucky Transitions will be marketed as a strategy to reduce bias and allow Medicaid funds to be used to support access to services in the setting preferred by the consumer. A variety of organizations and professionals will be targeted for marketing purposes, specifically those serving consumers in nursing facilities and ICFs/MR, community providers to whom residents of nursing facilities or ICFs/MR will be referred, state agency staff who have contact with residents of nursing facilities or ICFs/MR, and local organizations that support consumer choice.

Marketing materials will be distributed statewide and will include newspaper advertisements, radio spots, videos, and public presentations to promote awareness. Marketing materials will be created in conjunction with the Department for

Communications within the Cabinet for Health and Family Services and approved by the *Kentucky Transitions* Steering Committee. Materials will be made available in accessible formats upon request.

Pamphlets will be developed and distributed statewide through senior citizen centers, CILs, AAA's, brain injury services providers, hospitals, long-term care ombudsmen, local community-based services offices, and community mental health/mental retardation centers. The pamphlets will identify available services and eligibility criteria and encourage older adults, individuals with disabilities and individuals with mental retardation/developmental disabilities or acquired brain injuries to "spread the word" about community long-term care options.

Additional efforts will be made to notify physicians, advanced practice nurses, physician assistants, and office staff about this new option for individuals requiring nursing facility level of care. This frontline approach will be helpful in early identification of eligible clients who can transition when the eligibility criteria for nursing facility stay are fulfilled. It is essential for these individuals to be a part of any protocol involving diversion. Efforts will be made to engage all professional provider agencies and associations to assure they are cognizant of the program and understand potential ramifications for their constituents.

Within 30 days of approval of the protocol, the MFP Team will send a letter to every ICF/MR and nursing facility in Kentucky educating them on Kentucky Transitions and requesting their assistance in facilitating access to residents to MFP Transition Team Members, ICF/MR Transition Coordinators and the Long Term Care Ombudsman for education and transition. *Kentucky Transitions* staff also will carry a copy of the letter for presentation to facilities, if needed.

Training and Education

Ongoing training, education, and coaching/consultation are critical to ensure the effective implementation of *Kentucky Transitions*. Thus, a series of informational sessions, workshops, and training curricula will be developed to promote information and awareness and to facilitate the acquisition of needed knowledge, skills, and strategies for those responsible for implementing the transition process.

Provider Education

An *Orientation to Kentucky Transitions* workshop and associated marketing information and materials currently are under development. This workshop will offer a general overview of *Kentucky Transitions* as well as an opportunity for questions and discussion. Orientation Workshops will be tailored to meet the interests and concerns of the targeted audiences, including facility personnel, facility residents, community-based providers, guardians and family members, facility-based family groups, advocacy groups, community agencies, associations, and outreach and recruitment partners. Regional public forums also will be held across the state, and presentations will be made upon request by other interested parties. Workshops with targeted audiences will begin upon CMS approval of Kentucky's operational protocol.

Kentucky will provide a four-hour continuing education credit course for nursing facility administrators, ICF/MR staff, social workers, RNs and LPNs, discharge planners, utilization reviewers, and other hospital staff to learn about resources available to support participants in the community. A Workgroup will be convened to develop the curriculum and set the CEU's. The curriculum will include a consumer panel, a description of *Kentucky Transitions*, and presentations from independent living programs, community mental health/mental retardation programs, brain injury services programs, vocational rehabilitation services, and assistive technology programs. The course will be offered at a minimum of five statewide conferences per year and will be coordinated by the state's *Kentucky Transitions* community outreach coordinator.

In addition, the Kentucky Long-Term Care Ombudsman's Office will collaborate with the MFP Team to train local long-term care ombudsmen volunteers about *Kentucky Transitions*. The long-term care ombudsmen volunteers are seen as the primary identifiers of interested Nursing Facility residents and will have responsibility for assisting the individual or guardian in notifying the State Transition Team to begin the education, screening, and assessment process. They also will serve as educators and communicators about the program and serve as advocates and problem solvers when necessary. The long-term care ombudsmen are expected to follow up and follow through after making a referral to the State Transition Team. Moreover, long-term care ombudsmen will be trained to provide individual counseling and support to family members and guardians who may be fearful or resistant to having their relative leave the institutional environment.

Specific training will also be provided to state guardianship staff about *Kentucky Transitions*.

***Kentucky Transitions* Staff Education and Training**

Upon CMS approval of Kentucky's operational protocol, all hired and contract staff will be required to attend a full-day orientation within 30 days of being hired. The orientation will include an overview of *Kentucky Transitions*; roles, responsibilities, and expectations of various staff and partner agencies; strategies

Box 1. Training Modules for ABCs of *Kentucky Transitions*

- History, Purpose, & Philosophy
- Roles and Responsibilities
- Populations Served
- Introduction to the Kentucky Medicaid State Plan and Waivers
- Navigating Facilities
- Navigating Communities
- Building Relationships/Team Building
- Conflict Resolution and Problem Solving
- Educating Individuals to Support Informed Decision Making about Transitioning
- Screening and Assessment
- Person-Centered Planning
- Transition Plan Development and Timelines
- Human Rights, HIPAA , Confidentiality, and Legal/Ethical Issues
- Quality Monitoring and Quality of Life Assessments

for developing relationships with facilities and community resource providers; community resource identification and development; and required administrative and paperwork processes. Team-building exercises, conflict resolution strategies, and problem-solving techniques will be emphasized throughout the day. This orientation will serve as a foundation upon which the more extensive ABCs of *Kentucky Transitions* (described below) will build. The information presented will focus on embracing the philosophy of person-centered planning and its importance to the success of the *Kentucky Transitions* Initiative. The training will emphasize that *Kentucky Transitions* is about facility residents and their family members and guardians having choices in where and how they live in the community.

Because they hold primary responsibility for the provision of ongoing coaching and consultation to the ICF/MR Transition Coordinators and Regional Transition Teams, members of the State MFP Team and other state-level project staff will engage in periodic sessions to enhance team-building, conflict resolution and problem-solving skills, and effective coaching and consultation techniques. Sessions such as these are readily available through the Cabinet for Health and Family Services and other entities in the state government system.

A comprehensive training curriculum and handbook, the ABCs of *Kentucky Transitions*, is under development. This training will target state, regional, and partner project staff. A series of training modules are being designed to enhance the knowledge, skills, and strategies of the individuals involved in day-to-day implementation of *Kentucky Transitions*. The curricula will involve a full week of training to include didactic presentations, panel presentations, role plays and demonstrations, small group exercises, and experiential practice enhancement activities. Booster trainings will be offered throughout the life of the grant to ensure that effective implementation continues. See Box 1 for training modules contained in the ABCs of *Kentucky Transitions*. A specialized training on building community partnerships for housing will be provided by project staff hired in partnership with Kentucky Housing Corporation.

During Year 3 of the grant, a 15-30 minute video will be developed for use in outreach, education and training. The video will include participant testimony, national and statewide facts and data and specific transition strategies. The video will be largely from the perspective and experience of individuals who have transitioned from institutional placements through the Kentucky Transitions program. Since Kentucky plans to transition 20 people in Year 2, the video will be developed early in Year 3 using the experiences of those who transition in Year 2. The video will be resource during subsequent years when larger numbers will be transitioned. The video will be from the participant's perspective with regard to choice, services in the appropriate settings as well as the experience of transitioning through Kentucky Transitions and the resulting life changes after transitioning to the community.

STAKEHOLDER INVOLVEMENT

Stakeholder Involvement in Demonstration Planning

Initial Grant Application

From the beginning, Kentucky clearly understood implementing *Kentucky Transitions* would require a tapestry of stakeholders working in partnership from throughout the Commonwealth on behalf of the individuals served. Therefore, when Kentucky initially applied for the grant, the state assembled a strong coalition of partnering agencies, Medicaid recipients and their representatives, advocacy groups, state agencies, and providers from community and institutional settings. This group assisted in defining the parameters and scope of the initial proposal design and subsequent revisions.

Kentucky Transitions Steering Committee

Upon award of the demonstration, the initial stakeholder group was expanded into the *Kentucky Transitions* Steering Committee (for a listing of Steering Committee Members see Attachment 15). The invitation to participate on the Steering Committee was widely circulated among consumers, stakeholders and stakeholder groups already organized around issues related to the Demonstration. Participants self-selected and no interested participant was refused. In some instances, special invitations were proffered to ensure equitable representation in the planning process. The Steering Committee was comprised of representation from the following:

- Consumers
- Consumer Advocates
- AARP
- Area Development Districts
- NAMI Kentucky
- Center for Accessible Living
- ARC of Kentucky
- Advocates for the Reform of Medicaid Services (ARMS)
- Brain Injury Association of Kentucky
- Kentucky Home Health Association
- Kentucky Housing Corporation
- Kentucky Centers for Independent Living
- Kentucky Mental Health Coalition
- Kentucky Association of Regional Providers

- Kentuckians for Nursing Home Reform
- KAHSA
- Providers
 - Active Day, Inc.
 - Cardinal Hill
 - Cedar Lake Lodge
 - Independent Opportunities
 - Kaleidoscope Services
 - Lifeskills, Inc.
 - Kentucky Association of Private Providers
 - Kentucky Disabilities Coalition
 - Kentucky Commission for Deaf and Hard of Hearing
 - Kentucky Association of Health Care Facilities
 - Seven Counties Services
- State agencies
 - Cabinet for Health and Family Services Ombudsman Office
 - Department for Mental Health and Mental Retardation Services
 - Transportation Cabinet
 - Department for Protection and Advocacy
 - Health and Welfare Committee, Legislative Research Commission
 - Office of the Blind
 - Commission on Children with Special Health Care Needs
 - Office of Vocational Rehabilitation, Education Cabinet

The *Kentucky Transitions* Steering Committee met monthly throughout the first five months of the grant to guide the development of the Operational Protocol. All meetings were open to the public and individuals were given the opportunity to voice concerns, suggestions, and comments during the meeting. The Steering Committee has met twice since January and in the last meeting, a decision was made to meet bi-monthly. The Steering Committee is provided written updates through e-mail.

Kentucky developed a special website that can only be accessed by Steering Committee members. Through this website, members can access grant updates, meeting notices, create and participate in discussion groups and review and comment on developed materials. Unfortunately, to date, there has been minimal use of this website by the Steering Committee. This subject was discussed at a Steering Committee meeting on April 25. It was decided to continue to support the website and to provide additional training to Steering Committee Members on the features of the website.

Kentucky Transitions Workgroups

Kentucky initially created eight workgroups to assist in the development of the Operational Protocol. These workgroups were not limited to Steering Committee members but were open to anyone who indicated an interest in participating. While an invitation was given to all Steering Committee members to join a workgroup, not all chose to do so. The workgroups were comprised of consumers, advocates, community and institutional providers, professional organizations, state agency personnel, and organizational representatives. Initially, the following workgroups met from July 2007 through October 2007 to provide input to guide the development of the Operational Protocol (For a listing of workgroup members, see Attachment 15).

- Policy and Regulations
- Assessment and Service
- Transition and Monitoring
- Provider Network
- Housing
- Transportation
- Financial, Information Technology, & Reporting
- Operational Protocol

Recently, workgroups were reconvened and new workgroups established to assist in making changes to the Operational Protocol in response to comments from CMS regarding Kentucky's initial Operational Protocol Submission of December 2007 (For a listing of workgroup members, see Attachment 16). Participation in the workgroups was open to the Steering Committee and previous participants as well as any other interested parties. These workgroups assisted with the reformulation of the operating procedures outlined in the present version of Kentucky's Operational Protocol. For example, the Informed consent and Guardianship Workgroup provided extensive input into the reformulation of those procedures. Workgroup members also provided valuable input into the decision to utilize independent case managers as providers at the 6-month post-transition mark. Additionally, the Transportation Workgroup, as well as other interested stakeholders, proposed the monthly allotment as a possible solution to the

barriers encountered by waiver recipients utilizing the current Transportation Broker system. Members of the Outreach and Education Workgroup, as well as members of the Steering Committee reviewed marketing and outreach materials and made several recommendations to improve the readability and visual appeal of the materials.

The workgroups who met recently were:

- Informed Consent and Guardianship
- Provider Network
- Assessment and Services
- Transition and Monitoring
- Outreach and Education
- Transportation

Input from the Workgroups and the Steering Committee has been and continues to be critical to the successful implementation of Kentucky Transitions. Workgroups will be convened and added on an as needed basis to assist with implementation of Kentucky Transitions.

Stakeholder Involvement in Implementation Efforts

The *Kentucky Transitions* Steering Committee will continue to provide oversight and recommendations during the implementation and post implementation phases through face-to-face meetings and the website. Once implementation begins, the State will seek demonstration participants to serve on the Steering Committee. During the implementation phase, *Kentucky Transitions* workgroups will continue to meet to monitor the implementation process in their respective areas and to seek solutions to identified implementation barriers.

Specific Roles for Consumers

Consumers are integral members of the *Kentucky Transitions* program. In addition to serving on the *Kentucky Transitions* steering committee and workgroups, it is anticipated that transitioned consumers will provide technical assistance through advocacy organizations, such as CIL, BIAK, and the ARC of Kentucky, to provide information and education to consumers and families. Consumers participate as Steering Committee members and Workgroup members.

Specific Roles for Institutional Providers

Institutional providers are an essential element of *Kentucky Transitions*. Members of the Kentucky Association of Health Care Facilities, the Kentucky Association of Homes and Services for Aging, and staff from both the public and private ICFs/MRDD participated in the development of the initial grant application and serve on the *Kentucky Transitions* Steering Committee and workgroups. These partners will continue to provide care for

their residents as well as play a pivotal role in the transition process for those individuals who pursue community living. Facility staff will be instrumental in the transition planning process. The cooperation of all staff working with residents at institutions will be required to facilitate an effective transition and continuity of care between settings. Institutional administrators will need to understand and support *Kentucky Transitions* to assist with information dissemination and consumer education efforts. The professional organizations representing institutional providers may help support Kentucky Transitions by including advertisements and informational articles in their trade publications and websites. The Project Director will host regular meetings with representatives with all provider groups, including institutional providers, to facilitate communication and support implementation efforts.

BENEFITS AND SERVICES

Service Delivery Mechanism: Fee-for-service and/or self directed

Transition Populations:

Transition populations are Kentucky residents who have lived in a nursing facility (or a combination of hospitalization in a general hospital and a nursing facility) or ICF/MR for six consecutive months prior to transition, meet nursing facility or ICF/MR level of care and receive services through the Medicaid program in the month prior to transition. This includes seniors and people with physical disabilities, individuals between the ages of 21 and 65 with an acquired brain injury, and individuals with mental retardation/developmental disability.

Participants will be those who indicate a desire to transition from institutional care to community based care. Services will be provided during the 365 days after transition through the MFP Demonstration Project utilizing services currently available under Kentucky's currently approved 1915(c) waivers as well as expansions and additions to those services through HCBS Demonstration Services.

At the end of the demonstration period (day 366), MFP participants will transition from the MFP Demonstration Project into a variety of home and community based waivers. Kentucky has decided to offer the availability of the full array of potential waivers. This way the participant will have the ability to move into the waiver service package that meets their individual needs. Some waivers may be utilized more than others. Kentucky does not want to limit the availability of waivers or services. The waivers include:

- The Home and Community Based Waiver for the Aged and Disabled (Nursing Facility Level of Care) - No waiting list
- The Acquired Brain Injury Rehab Waiver (Nursing Facility Level of Care) – There is currently a waiting list but this should be resolved by newly approved ABI Long Term Waiver
- The Acquired Brain Injury Long Term Waiver (Nursing Facility Level of Care - Newly approved waiver with no waiting list
- The Supports for Community Living (MR/DD) Waiver (ICF/MR Level of Care) - 200 slots have been approved for this waiver for institutional transitions and 140 of those slots are available for those transitioning under MFP. Kentucky will be adding an additional 100 slots to the waiver this year. Additional slots will be added in the future if needed.
- The Michele P. (MR/DD) Waiver (ICF/MR Level of Care)-No waiting list

Current 1915 (c) Waiver Services are described in Attachment 17.

Kentucky has identified a service gap for the aged/disabled population between the existing Home and Community Based Waiver and the Nursing Facility. Kentucky is writing a new waiver which will target those immediately at risk for facility placement or who are transitioning from a facility into the community and who have care needs that exceed those available in the existing waiver. This waiver will include a residential component, nursing supports and expanded personal care, homemaking, respite and attendant care. This new waiver will be submitted to CMS by July 1, 2008 and will be available to those transitioning through MFP on Day 366. See Attachment XX.

Participants will receive services through the demonstration project service package upon transition and will move into a slot in the appropriate 1915(c) waiver on day 366. At that time, participants will be required to meet all eligibility requirements and level of care requirements for the waiver they will enter. Participants will be educated prior to transition on the requirements of the waiver and that services will end if they no longer meet those eligibility requirements. The services package during the demonstration period will vary by waiver population and by individual. All participants will be eligible for:

- Waiver Services
- MFP Demonstration Services
- MFP Supplemental Services
- State Plan Services

Services during the demonstration period will be provided by existing waiver providers. This will allow Kentucky to ensure that services are available to sustain the participant in the community setting on day 366, and that there will be no break in services. Kentucky has also convened an ongoing workgroup made up of providers, advocates and agency staff to identify possible expansions to the current provider network to allow a wider array of choice of providers for all waiver services. All participants also have the option to self direct services through the CDO program during the demonstration period following the criteria currently approved for the 1915(c) waivers which allows self direction of non-medical, non-residential services and the purchase of goods and services.

MFP Demonstration Service Array (See Attachment 18)

The MFP Demonstration Services Array consists of the following:

- The existing 1915 (c) Waiver Services - During the Demonstration Period (365 days after transition), participants will have access to the following waiver services based on Care Plan needs.
 - The Aged/Disabled Population will receive services provided through the HCB Waiver and the HCB Waiver Transition/Diversion Waiver.

- The MR/DD Population will receive services provided through the SCL Waiver and the Michelle P. Waiver.
- The ABI Population will receive services provided through the ABI Rehab and ABI Long Term Waivers
- MFP Demonstration Services – During the Demonstration Period (365 days after transition), participants will have access to the following services based on Care Plan needs. These services are additions to and expansions of existing waiver services. These services include:
 - Independent Assessment/Reassessment and Independent Case Management – (These services were defined by a workgroup made up of providers and advocates. The services will be provided by existing waiver providers. If the provider chooses to provide these services to a participant, they cannot provide any other waiver or demonstration service to that participant.)
 - Increased access to homemaking, personal care, attendant care, respite, and companion care,
 - Adult Day Medical and Social,
 - Community Living Supports,
 - Specialized Consultative Crisis Service,
 - Transportation**Transportation Benefit for MFP Demonstration Period as defined below based on input from the Transportation Workgroup:
 - Utilize existing Broker system for the current Medicaid Covered Services
 - Each participant will receive a monthly Allotment to cover transportation needs not met by the broker or for transportation outside the Broker's hours of operation. The participant will manage this allotment and can use it to hire friends, family member and others to provide transportation.
 - On-going monitoring of MFP participants monthly usage of voucher or monthly allotment for adjustment of the allotment based on need
 - Nursing Supports – LPN and RN,
 - Assistive Technology
 - Personal Emergency Response System.

MFP Supplemental Services - Services that will be one time services provided during pre-transition. These are services not usually paid for by Medicaid. These services include:

- Housing Modifications (up to \$15,000 or 10% of the value of the property);
- Any combination of the following services up to \$2,000:
 - Housing Deposits,
 - Utility Deposits,

- Pest Eradication,
- Household Goods,
- Household Setup,
- Food Stocking,
- Pre-Transition Transportation,
- Problem Solving Services – this service was developed to cover unforeseen expenses that might interfere with the participant transitioning (ex. Unpaid previous utility bills),
- Care Giver Training – this service was developed to cover expenses incurred by community care givers in participating in training at the facility prior to transition relative to the participants needs in the community., and
- Community Provider Supports – this service was developed to cover expenses incurred by community based providers in participating in care planning at the facility prior to transition relative to the participant's needs in the community.

CONSUMER SUPPORTS

The Kentucky Cabinet for Health and Family Services believes that all individuals should have the opportunity to live in an environment that offers them choice and self-direction. *Kentucky Transitions* provides supports, training and skill building to enable individuals to move into a community placement; education to consumers, family members, and guardians regarding community alternatives; and appropriate transitional planning and supports to ensure the success of community transitions.

The participant, family members, guardian, and significant others participate in the development and implementation of the Transition Plan. They are provided with Information regarding consumer rights, including the right to: select a provider, choose a preferred living arrangement and geographic area in which to reside, be actively involved in the transition process, be informed of challenges that may arise during the process, and provide input into the direction of the transition process. Natural support systems shall be sought, whenever possible.

State Transition Teams

The State Transition Team is a team comprised of a registered nurse and a social worker. The State Transition Team is the single point of entry into *Kentucky Transitions* for those indicating an interest in participating. The State Transition Team is notified by the participant and/or guardian, facility staff, long-term care ombudsmen, or others when the participant has expressed an interest in transitioning to the community. The State Transition Team then coordinates and tracks all transitions in progress across the state. The State Team notifies the appropriate Regional Transition Team of the person's interest to begin the education, screening, and assessment process. The State Team provides ongoing monitoring, coaching, and technical assistance to the Regional Transition Team to ensure the safety and well-being of all transition participants. State Transition Teams are hired by and report directly to the Department for Medicaid Services.

Regional Transition Teams

A Regional Transition Team is a team comprised of a registered nurse and a social worker. Along with a regional housing coordinator who participates on the team when housing needs exist, the team provides direct coordination of the participant's transition processes. The Regional Transition Team those provides education regarding *Kentucky Transitions* to those who are interested in transition, their legally appointed guardian, family members and other interested parties. They obtain informed consent and conduct a screening for eligibility to transition. The Team completes an assessment of the participant's needs utilizing a combination of review of MDS scores and medical records, interviews with facility staff and observation and interview with the participant. Using a team-based approach, the participant, family members, guardian, and significant others work together in developing and implementing the planning and transition process. During the first six months following transition, the Regional Transition Team closely monitors the participant in the community to ensure that transition plan provisions are met. They provide training and technical assistance to the

community case manager for transition of the case management function at six months. DMS will contract with DAIL to provide the staff which will make up the Regional Transition Teams. Utilizing the existing DAIL contract to hire the staff will allow Kentucky to have Teams in place within the next few months and will not require the lengthy RFP process. We are recommending a Transition Team/Participant ratio of 1/20 per year. Initially, DMS will have three Teams to begin the process. Additional teams will be added as indicated. The Teams will work out of Central Office initially and will be dispersed to regions of the state where participants desire to transition. As additional Teams are added, they will be located regionally based on transition volume. The Regional Transition Coordinators will report to the State Transition Team in matters related to Transitions.

Qualifications of State and Regional Transition Team Members

Registered Nurse qualifications include:

- A current Kentucky nursing license
- Experience in the care of older and/or adults with disabilities
- Leadership skills and experience managing small teams of professionals
- Ability to effectively deal with adversity and conflict
- Good bedside manner – ability to help strangers relax when asking difficult life-changing questions
- Ability to objectively assess and analyze the healthcare needs of transition participants
- Experience collaborating with physicians, pharmacists, and other healthcare service providers
- Ability to objectively perform screenings and assessments
- Ability to perform an assessment and analysis review of the nursing facility chart and Minimum Data Set (MDS) results
- Ability to coordinate with the participant and the team the development of community medical care, including but not limited to working with the nursing facility physician, identifying primary care physicians in the community willing to take on participants that may have extensive needs and setting up regular visits, and creating a connection with neighborhood pharmacies for delivery purposes

Social Worker qualifications include:

- Bachelor's degree in Social Work
- Kentucky state certification for social work
- Experience in the care of older and/or adults with disabilities
- Leadership skills and experience managing small teams of professionals
- Ability to objectively assess and analyze the psychological, social, and personal needs of transition participants
- Experience securing housing, transportation, nutrition, and other personal needs for adults who are elderly or disabled and who want to return to the community
- Ability to assist in performing screenings and assessments
- Ability to create a clinical care plan (CCP) in cooperation with an RN

- Ability to create regional community connections for local housing, transportation, and education/employment
- Ability to match needs to home and community-based options
- Ability to work with local resources, including but not limited to city agencies and community services, realtors, pharmacies, independent case managers, job placement companies, and translation services

Housing Coordinators

Kentucky has contracted with Kentucky Housing Corporation for three employees who will function as members of the Regional Transition Teams when housing is needed. These employees are experienced and knowledgeable in housing programs and trends across the state. They have been working to identify housing availability statewide and have identified subsidized housing programs and vouchers that are available. They have worked with Public Housing Authorities that are not under KHC to educate them on MFP and to establish relationships and identify available housing. They are creating a database of available housing, including apartments on the open market for those who don't meet the qualifications for housing. They will work directly with the participant to determine their housing needs and preferences. They will inspect all housing for safety and appropriateness before offering it as a choice for a participant. The Housing Coordinators are committed to locating safe, appropriate, inclusive housing that meets the needs and preferences of the participant. They are working very closely in the development of this program so that they are fully aware and involved in the process and the goals of the program.

Transition Process

Responsibilities of Regional Transition Teams include:

1. Providing one-on-one information and education to the participant, family members, and guardians regarding *Kentucky Transitions*.
2. Screening the participant for eligibility for *Kentucky Transitions*.
3. Performing a comprehensive assessment of the participant's clinical, social and housing needs.
4. Working with the participant, family members, guardian, facility staff, and significant others designated by the participant to develop a transition plan.
5. Educating the participant about community providers and supports. Making referrals to community providers and assisting with interviews and visits to providers to allow the participant to make informed provider choices.
6. Educating the participant about the Consumer Directed Option (CDO) which allows participants to self-direct some or all of their non-medical non-residential waiver services. All transitioning participants will be offered the choice to self-direct non-medical non residential waiver services within the community. Participants may choose to manage these services themselves or elect a representative to manage the services. The Regional Transition Team will assist the participant in securing a budget and developing a CDO plan. The Consumer Directed Option (CDO) is

coordinated through a Support Broker for the region. Currently, the Commonwealth of Kentucky's Area Agencies on Aging (AAAs) serve as Support Brokers for the HCB population under the auspices of the Department for Aging and Independent Living (DAIL). The Community Mental Health Centers (CMHCs) serve as Support Brokers for the SCL and ABI populations. At six months, the Support Broker will provide case management functions and will continue to do so after day 366 if the participant chooses to continue in the CDO program.

7. Coordinating the transition process for the participant in a responsive manner.
8. Developing a person-centered plan in the appropriate Facility Transition Plan format that provides all necessary information for the smooth transition of the participant into a community setting.
9. Ensuring that an assessment to determine level of care for ongoing 1915 (c) waiver eligibility is performed at least two months prior to the end of the Demonstration Period to ensure an adequate amount of time to address problems/issues if the participant does not meet waiver eligibility requirements.
10. During the fifth month post transition, the Regional Transition Team will assist the participant in locating a Case Manager from the available 1915 (c) waiver providers. The Team will work with the Case Manager to assure that a smooth transition can occur after six months.
11. Monitoring the participant in the community through weekly contacts with one contact a month being on-site for the first six months after transition and monthly contacts for the next six months.

Provider Selection

The participant will be given a choice of providers in the area where the participant has determined that he or she would like to live. The process of provider selection is driven by the participant. The Regional Transition Team is available to guide and support the participant through the selection process.

To achieve the overall goal of helping transition participants move safely to new residences while minimizing relocation stress, the Regional Transition Team will:

- Remain focused on best outcomes for transition participants throughout the process
- Assure that transition participant choices and preferences are considered and honored
- Acknowledge participant and staff feelings of loss, mistrust, or confusion
- Offer a person-centered approach necessary for a successful relocation process
- Ensure a safe and timely transfer of transition participants to new residences
- Conduct business professionally and collaboratively
- Support the daily routines of transition participants and nursing facility operations
- Create a blameless environment focusing on positive outcomes and solutions
- Create a cost-effective care plan, while maximizing funding resources

Transition Assessment

During the assessment process, the Regional Transition Team will conduct record reviews, staff interviews, and participant observations and interactions to gather information needed to gain an accurate reflection of the services, needs, and supports necessary to maintain the participant in the community. The Regional Transition Team develops individualized detailing of all healthcare issues of transition participants and corresponding management strategies. The care plan also delineates caregiver responsibilities for contact and follow-up with the primary care physician and explains the role of medication regimen, home health needs, a post-transition healthcare coordinator, durable medical equipment needs, etc. The plan serves as the basis upon which participant home and community-based services are established. The Regional Transition Team assesses all applicable participants and identifies available informal supports in advance of using formal supports and funding sources.

Transition Plan Development and Review

The transition plan is developed using the person-centered planning approach and is based on the participant's current individual support plan, clinical care plan, and/or medical assessment. Based on the results of a needs assessment, the Regional Transition Team works with the participant to develop a comprehensive transition plan delineating all of the formal and informal services needed to allow participants to successfully live in the setting of their choice. Throughout the planning process, activities critical to the success of the transition are identified. The Regional Transition Team monitors completion of all pre-move tasks. Timely reporting of task completion is crucial to ensure that transition of the participant is not delayed unnecessarily. The transition plan is based on the services and the providers chosen by the participants or their legal guardian.

The transition plan ensures that information in the discharge package is complete and updated by the day of discharge. It also provides:

- an outline of how care will be coordinated if continuing treatment involves multiple caregivers;
- a description of what agencies will be involved post-discharge and the contact person for each agency (name, role, and phone number);
- medications, medical procedures, and a contact person at the discharging facility who can be available for follow-up questions; and
- Information about the availability of the Regional Transition Team for follow-up questions and consultation and their plan to provide follow-up for each participant following transition;
- Back-up Plan.

Upon completion of the planning process, the Regional Transition Team will draft a copy of the transition plan and submit it to the participant for review. The transition plan is then forwarded to the State Transition Team for review and approval.

Waiver Services Plan of Care/Prior Authorization

Prior to discharge, the Regional Transition Team will complete the Map 109-Plan of Care/Prior Authorization for Waiver Services (see Attachment 19). The plan of care includes:

- identification of necessary services and supports, including total hours and costs,
- documentation of services to be provided,
- selection of providers for each service,
- documentation of unmet needs and how they will be addressed, and
- provisions for emergency back-up services.

The MAP 109 will be submitted to the State Transition Team for service approval.

Access to Back-Up Systems and Supports

During the Transition Planning process, the Regional Transition Team will work with the participant or the legal guardian to identify the participant's natural circle of support. This natural support system could include family, friends, neighbors, and community based providers who could be utilized to assist with services and provide back-up support.

During the Transition Planning process, the Regional Transition Team and the participant or the legal guardian will identify potential risks and risk management needs based on the participant's individual needs. An emergency back-up plan will be developed which will address how these risks will be managed and how services will be provided if a primary service provider is not available. The plan will address services and risks, who will be contacted in the event that a service provider is not available to provide a service. The plan will include who will be contacted and at what point. The Regional Transition Team will track all access to back-up systems and supports to ensure that the existing care plan continues to meet the participant's needs. The Regional Transition Teams will be available 24/7 on an on-call basis to assist participants with failure of a back-up system. This will be a rolling on-call among all Regional Transition Teams. No one Team will be on call 24/7. They will be on call to provide support, but not to provide services. The emergency back-up plan will contain all levels of back-up which will be provided by participant identified friends, family members and providers.

Each participant will be provided with education and written information in a Back-Up Systems folder instructing them on who to contact any time in the event that an emergency occurs or that the Back-Up system must be utilized. Participants will be instructed to contact their Transition Team anytime they have an emergency or activate their Back-Up system. This information will be tracked in a database and analyzed by the State and Regional Transition Teams to assess the effectiveness of each participant's services and Back-up System. This data will be used to provide required information for quality purposes and the outcomes of problem resolution. The Back-Up Systems folder will be updated and written changes made to same with any new

contacts or change of provider. The Regional Transition Team and independent case managers or support brokers will be available 24/7 to assist with emergency back-up services.

For medical emergencies, participants may use a Personal Emergency Response System (PERS), after-hour contact with physicians, Urgent Care Centers, Hospital Emergency Rooms, and 911/Ambulance Services. Additionally, KYHealth Choices maintains a Nurse Information Line [(877-844-6970)] to provide 24/7 access to health care information and advice. This Nurse Information Line does not replace the participant's primary care physician (PCP) and cannot provide referrals or authorize services. Crisis and information services are available through the Regional Mental Health/Mental Retardation comprehensive Care Centers.

Planning/Discharge Meeting

The Planning/Discharge Meeting is designed to ensure that the transition process is on track. The Regional Transition Team will be responsible for facilitating this meeting for the purpose of getting a clear picture of the updated status of the move and to ensure that all potential barriers have been addressed. The meeting will include a discussion about several aspects of the transition process to ensure that: cross-training of staff has been completed; feedback is received and utilized to make any needed revisions to the transition plan; adaptive equipment/assistive technology identified for purchase has been prior authorized and will be available by the date of the move; necessary home modifications have been made; all supports and services are in place and emergency back-up systems have been established as indicated; the final transition plan has been distributed; and a move date has been confirmed.

Closure Call

The Regional Transition Team contacts all community providers to arrange for a closure call prior to the designated move date. The purpose of the closure call is to finalize any outstanding details and to ensure that all aspects of the plan are in process. After the closure call, the Regional Transition Team confirms the scheduled date and time for the move with the facility.

Day of the Move

The participant, family members, guardian, and/or staff from the facility will ensure that the items belonging to the participant are packed for the move. A signature indicating verification of the items on the checklist will be made by the staff providing transportation. Upon arrival at the community home, the participant, family member, guardian, or community staff will verify that all items have arrived and will sign off on the checklist indicating receipt.

After the Move

In an effort to provide an opportunity for a successful transition to community life, the transition will not be considered complete until the end of the demonstration year. The following immediate and ongoing support and monitoring activities are designed to support the participant to remain in the community.

- The Regional Transition Team will make phone contact with the participant the day after the move to obtain feedback on the move and assess the participant's adjustment.
- The Regional Transition Team, State Transition Team, and other appropriate staff will be available to community providers for consultation, training, and technical assistance, as needed.
- Pre-arranged post-transition quality monitoring visits will be conducted periodically to discuss the participant's adjustment to the community setting and to provide consultation to the community provider regarding issues that may have arisen since the transition (see Quality Management Section of Operational Protocol).
- Issues identified during the post-transition quality monitoring visits will be addressed by the appropriate community providers, Regional Transition Team, and State Transition Teams, as appropriate. Information obtained during follow-up visits will be documented and reviewed at the participant and aggregate level for purposes of continuous quality improvement. Ongoing coaching and technical assistance will be provided to address emerging issues that may disrupt life in the community.

The Regional Transition Team provides case management services during the initial 6 months and will be available on an on-call basis 24/7 to respond to emergencies and individual requests for critical back-up. In conjunction with the State Transition Team, the Regional Transition Team monitors timeliness of responses to consumer calls and documents the number and type of participant requests for emergency back-up. Independent case managers and CDO support brokers will provide this information to the Regional Transition Team after the initial 6-month period. Participants can report suspected fraud and abuse using Medicaid's Fraud and Abuse Hotline at (800) 372-2970.

Complaint and Resolution Process

Participants will be given contact information for the State MFP Team for complaints about services or complaints about a Transition Coordinator. The Team will track and investigate all complaints.

If a participant is denied a service under the KyHealth Choices Plan (Kentucky Medicaid), they have the right to request a hearing through the State Hearings Branch. Written notification is provided to participants whenever a covered service is denied, reduced, or suspended. The right to a hearing is provided along with the written notice. The participant may request a hearing in writing (see Attachment 20 for a sample

letter). If the participant is denied a service they are currently receiving, their written request must be mailed within 10 days of receipt of the denial notice in order to continue receiving the service. The participant is provided written notice of the time and location of the scheduled hearing. The hearing will be scheduled no more than 30 days from the date of the hearing request. Prior to the hearing, the participant has the right to examine their case file, documents, and records.

At the hearing, the participant has the opportunity to describe their concern to the hearing officer and their rationale for why they should receive the denied service. Participants may be represented by counsel or have a friend or witness accompany them.

If the participant feels that the hearing officer's decision is wrong, an appeal can be filed in Circuit Court within 30 days of the date of the final order.

SELF-DIRECTION

In Kentucky, the Consumer Directed Option (CDO) allows eligible Medicaid 1915 (c) waiver members to choose their own providers for non-medical, non-residential waiver services. CDO is offered to Kentucky Medicaid waiver members who currently receive or become eligible for services through:

- the Home and Community Based waiver (HCB) (Aged/Disabled),
- the Supports for Community Living waiver (SCL) (MR and DD), and
- the Acquired Brain Injury waiver (ABI).

The following non-medical, non-residential services can be self directed through CDO:

- HCB Non-medical services
 - Respite, Personal Care, Homemaking and Attendant Care
- SCL Non-medical & Non-residential services:
 - Respite, Community Living Supports, Community Habilitation
- ABI Non-medical services
 - Respite, Companion Care, Personal Care

CDO allows the member the ability to hire family members, friends, neighbors, etc. to provide their non-medical waiver services. Members also have the ability to purchase goods and services. This allows members greater flexibility in the delivery of the services they received.

The State Area Agencies on Aging (AAA's) currently act as Support Brokers for the HCB population for the CDO Program. Community Mental Health Centers act as Support Brokers for the SCL and ABI populations. Once a member chooses the CDO option, the Support Broker helps the member in getting the services needed. Support brokers assist the member in developing a plan of care based on their budget and in training and hiring their service providers. The member (or their chosen representative) work with the Support Broker to develop a plan of care, support spending plan and emergency backup plan.

For those transitioning through Kentucky Transitions, the Regional Transition Teams and ICF Transition Coordinators will fulfill the Support Broker role. At four months after transition, they will assist the participant in identifying and selecting a Support Broker and work with the Support Broker to transition the function to them at six months. The Team will:

- Provide the participants with information about the benefits and potential liabilities associated with CDO and provide the information in a timely basis to permit informed decision making by the participant
- Explain the circumstances under which CDO is terminated voluntarily or involuntarily
- Explain the safeguards to ensure continuity of services and assure participant health and welfare during the transition period from the institution to the community
- Work with the participant to obtain a budget in accordance with State policies

The Area Development Districts provide Fiscal Intermediary services for members enrolled in CDO. The Fiscal Intermediary tracks the member's budget and paid claims. Fiscal Intermediaries:

- Maintain a separate budget for each MFP participant
- Track and report disbursements and balance of participant's budget
- Provide participants with periodic reports of expenditures and the status of the CDO budget.

Utilizing the CDO option, the member is responsible for:

- Hiring, training, scheduling, supervising and firing their staff;
- Following the approved plan of care/support spending plan;
- Staying within the approved Medicaid budget;
- Submitting paperwork timely.

If the member chooses to no longer receive CDO services or if CDO services are terminated for any reason, the support broker assists the member in identifying a traditional provider and returning to traditional service delivery. The member will not lose eligibility for traditional services by participating in the CDO program or returning to traditional services.

See Attachment 21 Self-Direction.

QUALITY MANAGEMENT

Following is the detail for the quality management strategies and assurances that will be adopted and integrated into Kentucky Transitions activities. Strategies include modification of quality management systems, risk assessment and mitigation, 24 hour emergency back-up planning and incident reporting and management.

Existing Quality Management Systems

Kentucky Transitions targets three populations for transition to community life: residents of nursing facilities (both elderly and physically disabled), individuals with mental retardation or developmental disabilities, and individuals with acquired brain injuries, all of which shall have resided in an institution a minimum of six consecutive months. Because these populations are served through existing 1915(c) waiver programs, Quality Management Systems are already in place and will continue to be utilized (see Attachments 22, 23, and 24 for QMS descriptions for existing waivers). To that end, *Kentucky Transitions* will incorporate, at a minimum, the same level of quality assurance and improvement activities articulated in Appendix H of the existing 1915(c) HCBS waiver application and apply the same standards to the demonstration ;and supplemental services.. Kentucky's quality plan has been approved by CMS in a waiver amendment that added CDO to the existing HCB Waiver and approval of a new SCL and Long Term ABI Waivers.

The Department for Mental Health/Mental Retardation enrolls and certifies providers who serve individuals through the SCL program. Background checks and employee training requirements are a component of the enrollment and ongoing certification process. Enrollment, training and certification processes required by DMS of ABI and HCB providers mirror the requirements of the SCL providers.

Proposed Modifications to Existing Quality Management Systems

One of Kentucky's proposed program goals includes the expansion of the state's current Quality Management System (QMS) to include periodic monitoring of Kentucky Transitions participants by the Regional Transition Teams. Currently, routine monitoring occurs by the case manager or support broker. When the transition occurs to a case manager or support broker, continued monitoring by the Regional Transition Teams at a lesser frequency pre-transition will compliment their efforts. Collecting and analyzing information about the experiences of participants will allow Kentucky to ensure that Kentucky Transitions is effective in accomplishing its overall goal of establishing policies and procedures to facilitate the successful transition of individuals from institutions to the community, thereby, furthering its rebalancing efforts. The ongoing analysis of information with feedback loops to a variety of stakeholders will provide relevant, timely and useful information to guide decision-making and program improvement initiatives at the individual, program, practice, system and policy levels.

In addition to the existing monitoring and quality assurance processes already in place for traditional waiver participants, those participating in *Kentucky Transitions* will have the added benefit of an enhanced monitoring and quality management system during the transition period. Achieving quality outcomes for participants in *Kentucky Transitions*

is a priority among all state and contracted entities, and each plays an integral role in the quality assurance process.

Kentucky Transitions will adopt and adapt, as needed, the transition monitoring process developed and used by the Kentucky Department for Medicaid Services and the Department for Mental Health and Mental Retardation Services under the current transition initiative for individuals residing in ICFs/MRDD. Designed to ensure the health, safety, and welfare of transition participants, the transition monitoring process includes extensive on-site review of the participant's transition plan, current service and support systems, and level of adjustment.

During the first six months following transition, Regional Transition Teams will conduct weekly transition monitoring by phone and on-site visits. At least one weekly contact per month will be on-site and face-to-face. Upon transition of the participant to an independent case manager or support broker at six months, the Regional Transition Teams will continue conducting monthly monitoring visits during the final six months of the demonstration period. Participant-specific information gathered during these visits will guide decisions about needed modifications to care plans to mitigate or ameliorate issues that may potentially disrupt a participant's continued residence in the community. Regional Transition Teams can access specialized technical assistance and consultation from the State Transition Team, as needed. Data elements will include but not be limited to, information about whether the (1) Participant received the right type of care at the right frequency to remain safe in their community setting; (2) Participant had a displacement from their community setting and the reason for the displacement; and, (3) Participant characteristics made a difference in maintaining successful community placement. Additionally, Kentucky Transitions will adhere to the protocol established and agreed upon by CMS and Mathematica regarding the administration of the required Quality of Life Assessment and the subsequent analysis of the information for data informed decision recommendations.

At a system-level, *Kentucky Transitions* staff will monitor timeliness of responses to consumer calls and document the number and type of participant requests for emergency back-up. Additionally, the number of transitioned participants who re-enter institutions or hospitals and the reasons for doing so will be tracked. This aggregate information will aid in decision making and quality improvement activities. For example, the State Transition Team will use this information to identify common characteristics and trends across participants who re-enter institutions to determine program or process modifications that need to be refined or modified. Similarly, data on continuity of community residence can be used to forecast utilization rates for nursing facilities and home and community-based services.

Quality Management Assurances

Risk Assessment and Mitigation

Particularly during the assessment process and development of the service plan, the Regional Transition Team will work in collaboration with the Kentucky Transitions participant and their family members in addition to the following person when applicable:

guardian, Support Broker, Case Manager, or Representative to ensure the participant's needs are adequately addressed and identify barriers and risks for residing in the community. As situations change or additional needs are realized, the team will update risk assessment information and update the plan of care or emergency back-up plan accordingly.

Emergency Back-Up

An emergency back-up plan will be developed for each Kentucky Transitions participant with appropriate contact information at any point in time in a twenty-four (24) hour calendar day (See Attachment 25). For life or limb-threatening emergencies, the standard "CALL 911" or some other specific emergency number will be offered. The emergency back-up plan is designated for situations wherein an attendant scheduled to provide support services does not arrive in the home to provide homemaking, personal care, transportation, respite, etc. as scheduled. Contact options will be listed in detail on the emergency back-up plan and the plan will be posted in a readily accessible place for the participant. Local emergency department phone numbers will also be posted for life, safety, or limb-threatening emergencies (fire department, pharmacy, ambulance, police, poison control, etc.) An emergency back-up plan is also a requirement for those who choose to self-direct their services, employees and goods. The emergency back-up plan will assist with risk management. All emergency back-up providers will sign the plan of care.

Incident Reporting and Management

Departments responsible for the administration of each of the existing waiver programs have comprehensive incident reporting requirements and management strategies. The existing requirements will be applied to the demonstration participants.

Currently, DMH/MR has a Risk Review Committee that reviews critical incidents for many programs including SCL with a "goal to balance the quality of life and self-determination of the individuals and to ensure safety to the greatest possible extent." This ten-member Risk Review Committee reviews critical incidents, establishes resolutions to critical incidents in addition to remedial and restorative measure while making policy recommendations to the Commissioner of DMH/MR. Critical incidents for Supports for Community Living Participants range from incidents of abuse, neglect, or exploitation, medication errors resulting in death, coma, paralysis or other major permanent loss of function, to any incidents or complaints that generate an investigation by any state or federal agency.

Incident reports, risk review and analysis by the Committee includes services and programs certified or contracted for community based services, state owned, managed or contracted intermediate care facility for individuals with mental retardation or a developmental disability (ICF/MR); and state owned, managed or operated nursing facilities. All programs are required to document numerous types of incidents in addition to the critical events. The three (3) classes of incidents that also encompass the critical events include the following:

Class I:

- Be minor in nature and not create a serious consequence;
- Not require an investigation by the provider agency;
- Be reported to the case manager or support broker within twenty-four (24) hours;
- Be reported to the guardian as directed by the guardian; and
- Be retained on file at the provider and case management or support brokerage agency.

Class II:

- Be serious in nature;
- Involve the use of physical or chemical restraint;
- Require an investigation which shall be initiated by the provider agency within twenty (24) hours of discovery, and shall involve the case manager or support broker; and
- Be reported by the provider agency to: the case manager or support broker within twenty-four (24) hours of discover; the guardian within twenty –four (24) hours of discovery; the assistant director of the Division of Mental Retardation, Department for Mental Health and Mental Retardation Services, or designee, within ten (10) calendar days of discovery, and shall include a complete written report of the incident investigation and follow up.

Class III:

- Be grave in nature;
- Involve suspected abuse, neglect, or exploitation;
- Involve a medication error which requires a medical intervention; or
- Be a death.
- Be immediately investigated by the provider agency, and the investigation shall involve the case manager or support broker; and
- Be reported by the provider agency to: the case manager or support broker within eight (8) hours of discovery; the Department for Community Based Services immediately upon discover, if involving suspected abuse, neglect, or exploitation in accordance with KRS Chapter 209, the guardian within eight (8) hours of discovery; and, the assistant director of the Division of Mental Retardation, DMHMRS, or designee, within eight (8) hours of discovery and shall include a complete written report of the incident investigation and follow-up within seven (7) calendar days of discover. If an incident occurs after 5 p.m. EST on a

weekday, or occurs on a weekend or holiday, notification to DMR shall occur on the following business day.

In the event of a death, additional submission requirements include a current plan of care, list of prescribed medications including PRN medications, crisis plan; Medication Administration Review forms for the current and previous month; staff notes from the current and previous month including details of physician and emergency room visits; any additional information required by DMHMRS, a coroner's report when received, and if performed, an autopsy report when received. Furthermore, all medication errors are required to be reported to the Assistant Director of the Division of Mental Retardation, DMHMRS, or designee on a monthly medication error report form by the 15th of the following month.

Reporting requirements and follow-up procedures for Acquired Brain Injury providers mirror the three class categorizations required by Supports for Community Living providers; however, providers within the Home and Community Based waiver are required to develop their own incident reporting guidelines for staff within the parameters of various regulatory requirements one of which is the protocol for reporting critical events to the proper authorities within the proper timeframes, "Kentucky Revised Statutes (KRS) 209 requires staff or any other person who has reason to suspect or actual knowledge that a vulnerable child or adult has been abused, neglected, or exploited to report immediately upon discovery to the DCBS Protection and Permanency office." The Department for Aging and Independent Living monitors Home and Community Based provider's policies and procedures and approves or requires revisions as necessary. Department staff, support brokers, consumers, representatives, and providers are all required to receive training regarding the requirements of KRS 209.

In regards to self-directed care, the support broker is required to document the report number made to DCBS Protection and Permanency office and the name of the person they reported the incident to in their case notes. State staff or the designee reviews and makes a determination if further action is necessary to ensure the health, safety, and welfare of the consumer. A standardized incident reporting form is used to also report to the support broker within twenty-four (24) hours and retained on file at support brokerage agency. Written reports are also required along with follow-up actions to further ensure well-being.

Kentucky Transitions staff will build upon the existing structure of the DMHMRS Risk Management Committee to systematically review incidents of risk for participants of the demonstration as a group and also compare incidents of risk with non demonstration participants. Accordingly, any trends that indicate the need for change in policy will be communicated to the *Kentucky Transitions* Project Director. (See Attachment 26a and 26b)

HOUSING

Kentucky Transitions has contracted with Kentucky Housing Corporation (KHC) to provide three staff knowledgeable about housing programs in Kentucky to act as Housing Coordinators. As members of the State and Regional Transition Teams, Housing Coordinators work to ensure that all participants have access to affordable, accessible, integrated housing so that they can successfully transition from institutional settings to community-based housing.

KHC has provided the following information in regard to the availability of housing in Kentucky:

- Assisted Rental Housing Report (See Attachment 27) - this report is an extensive compilation of all the units by county in Kentucky receiving HOME and Low-Income Housing Tax Credits. The shaded units in this Report are Project-Based Rental Assistance units and are administered by Kentucky Housing Corporation. All the units within this Report are easily identified by accessibility and/or elderly.
- Project-Based Rental Assistance Vacancy Report (See Attachment 28) - this report details the number by county of Project-Based Rental units available in Kentucky for the month of May, specifically. This report is generated monthly. For the month of May 2008, there were 1,112 vacant Project-Based Rental units throughout Kentucky. Of this number, 410 units are designated handicapped and/or elderly.
- Kentucky Housing Corporation Programs Overview (See Attachment 29) - this booklet details all the programs administered through Kentucky Housing Corporation. For example, Kentucky Housing Corporation administers the HOME Investment Partnership Program, Low-Income Housing Tax Credit Program and Rural Housing Service. These housing assistance programs will be available and a viable option to eligible Money Follows the Person individuals.

Regional Housing Coordinators have been actively developing partnerships with housing providers across Kentucky. Kentucky Housing Corporation administers rental assistance within 87 of the 120 counties in Kentucky. For rental assistance in the counties not administered by Kentucky Housing Corporation, the Regional Housing Coordinators have developed strong relationships and partnerships with the respective housing providers.

Additionally and as stated in the Housing Protocol, Kentucky Housing Corporation administers 15,800 units subsidized under Section 8 of the United States Housing Act - Housing Choice Voucher (HCV). The State of Kentucky has a limited supply of HCVs. HCVs will be offered based on availability. At this time, the waiting list for HCVs is closed. If necessary, the state partners in this demonstration program will petition the

federal Department of Housing and Urban Development to seek additional federally-funded vouchers for this population.

The *Kentucky Transitions* Housing Coordinators have access to various resources to help identify appropriate and acceptable housing units for participants:

- Assisted Rental Housing Directory: This directory is a complete compilation of all rental housing developments that were created with the assistance of federal and/or state housing dollars. The directory shows a county-by-county listing of projects and includes the number of units, whether the properties have units accessible to persons with disabilities, and contact information.
- Project-Based Rental Housing Vacancy Report: In an effort to assist households with low incomes locate subsidized rental housing; KHC publishes a list of housing developments with vacancies. This report, produced monthly, identifies where participants may be able to gain quick access to housing.
- Public Housing Inventory: Kentucky has over 100 public housing agencies across the state subsidized with federal U.S. Department of Housing and Urban Development (HUD) monies. KHC has developed good working relationships with many of them through the Safe Havens program. In addition, KHC has an excellent partnership with the HUD Kentucky State Office, which has jurisdiction over public housing agencies. HUD Secretary Alfonse Jackson recently issued written communication to public housing authorities describing the Department's expectations for these agencies to partner with the *Kentucky Transitions* program.
- HUD Project-Based Database: The HUD Kentucky State Office maintains a database of project-based properties in Kentucky. Representatives of the KHC Rental Administration Department will work with HUD to use this resource for assisting *Kentucky Transitions* participants.
- Rural Housing Service Inventory: The U.S. Department of Agriculture Rural Housing Service provides funds for the development of assisted rental housing projects in rural areas. KHC will work with the Kentucky Rural Housing Service office to obtain current lists of available units and project vacancies.
- Kentucky Rents: KHC maintains the website www.kyrents.org. This site offers landlords and property managers the opportunity to advertise at no cost the availability of housing units for rent. Landlords voluntarily update information on this site to provide the location of vacancies, unit amenities, and contact information.

Federally assisted housing developments must comply with Section 504 requirements for accessibility. Because of this, public housing authorities and project-based properties maintain a certain percentage of units that are accessible to persons with disabilities.

Housing units that are assisted with federal HUD funds generally also require that tenant payments not exceed 30% of monthly household income. This prevents households from becoming rent burdened.

The Housing Choice Voucher (HCV) program provides rental assistance to households and enables them to access housing in the community. Households interested in this form of rental assistance must begin the process by completing an application. Because this program offers much flexibility in housing choice, the program is very popular, and KHC receives many applications for assistance. The KHC Rental Assistance Department maintains a waiting list of applicants. Because Kentucky currently has large waiting lists for vouchers, KHC will partner with DMS and other agencies involved in *Kentucky Transitions* to seek additional funding for the HCV program to provide additional vouchers for this population. *Kentucky Transitions* will work with KHC to identify housing resources and consider the adequacy of housing supply.

It is anticipated that all participants referred through *Kentucky Transitions* will be able to find appropriate housing within their community of choice. However, there are some parts of rural Kentucky where housing choices are much more limited than in other areas. The *Kentucky Transitions* Housing Coordinators will make every reasonable attempt to help participants to transition successfully back to the community of their choice.

As the Regional Transition Teams collect client data for referral to the *Kentucky Transitions* Housing Coordinators, participants will be asked to identify their preferred community for relocation. To provide more flexibility and choice, the Transition Team will also ask participants to identify second and third choices of destination communities. The *Kentucky Transitions* Housing Coordinators will attempt to exhaust all possibilities for appropriate housing in the first community of choice. In the event that housing is not available in the first community of choice, the *Kentucky Transitions* Housing Coordinators will work with the participant, Transition Team, and other stakeholders to identify suitable housing in the second or third preferred community. Close communication with all parties will be essential to address the complete range of needs impacted by housing location. For example, the Transition Team will help ensure that adequate transportation is available for participants who relocate to community-based housing, which will be especially important for those participants who relocate to the second or third community of choice.

KHC also is the state public housing authority that administers HUD federal housing assistance programs. The U.S. Department of HUD clearly supports *Kentucky Transitions*, as noted in a recent letter from Secretary Alfonse Jackson notifying public housing agencies that they should partner with state and local agencies on the *Kentucky Transitions* program. Kentucky Housing also has an excellent working relationship with the HUD Kentucky State Office, which oversees all public housing agencies in the state, and will use that relationship to encourage other PHAs to partner with *Kentucky Transitions*. KHC has already developed many partnerships with PHAs through the Safe Havens program.

KHC has convened an internal team which will be the central body for developing strategies to promote availability, affordability, and accessibility of housing for *Kentucky Transitions* participants. This team consists of talented and experienced representatives

from Specialized Housing Resources; Planning and Performance; Rental Assistance; Rental Administration; Housing Finance and Construction; Human Resources and Information Technology, all of whom are dedicated to the successful implementation of *Kentucky Transitions*.

As the state housing finance agency, KHC administers a wide range of federal and state housing programs. As the administrator of these programs, KHC team members have a full understanding of housing programs across the state and how to make them accessible to *Kentucky Transitions* participants.

KHC also staffs the Kentucky Housing Policy Advisory Committee. This body, created by statute, serves as the primary housing policy advisory entity for Kentucky. KHC staff will take steps to inform this committee of the importance of *Kentucky Transitions* and enlist their assistance with advancing the initiative.

Former Governor Ernie Fletcher recently signed an executive order formally establishing the Kentucky Interagency Council on Homelessness (KICH). The council is composed of decision makers from various state-level cabinets as well as advocates and service providers for the homeless and others with special needs. The KICH is currently working with regional groups to develop strategies for implementing the state's Ten-Year Plan to End Chronic Homelessness. The prevention of homelessness is an important issue area for these strategies. Prevention requires adequate housing resources in the community as well as effective strategies for discharging individuals from institutions. While *Kentucky Transitions* is not a program for serving persons who experience homelessness, regional implementation strategies that help ensure adequate housing resources and address the transition from institutional settings to community-based housing will have a positive impact on helping *Kentucky Transitions* participants relocate to housing in the community.

Money Follows the Person Rebalancing Demonstration Operational Protocol Instruction Guide Appendix B: Types of Supported Housing				
Type of Qualified Housing	Number of Each Type of Qualified Residences	State Definition of Housing Settings and Number of Each	Number of Each Settings	How Regulated
Home owned or leased by participant or participant's family member	No way of determining these data	<ul style="list-style-type: none"> • Home leased by participant or family • Home owned by participant • Home owned by family 	No way of determining these data	<ul style="list-style-type: none"> • Lease with a landlord • NA • NA
Apartment with an individual lease, lockable access and egress and which includes living, sleeping, bathing, and cooking areas over which the participant or participant's family has domain and control	Data are unavailable	<ul style="list-style-type: none"> • Apartment building • Public housing units • <i>Kentucky Transitions</i> Assisted Living 	Data are unavailable	<ul style="list-style-type: none"> • Lease with a landlord • Public Housing Agency • Lease with a landlord and state regulations
Residence in a community-based residential setting in which no more than 4 unrelated participants reside	Data are unavailable	<ul style="list-style-type: none"> • Staffed Residence • Group Home • Adult Foster Care 	Data are unavailable	<ul style="list-style-type: none"> • State agency license regulations • State agency license regulations • State agency license regulations

CONTINUITY OF CARE POST DEMONSTRATION

Services for participants transitioning from institutional settings through Kentucky Transitions will be provided after the Demonstration Period through one of the existing approved 1915(c) waivers. The state has reviewed its current waivers in terms of slot availability and is confident that slot will be available in all waivers for Kentucky Transitions participants at the end of the demonstration period. If there is a need for additional slots, Kentucky will request additional slots. Kentucky is in the process of adding 100 additional slots to SCL waiver

Kentucky has reviewed its waivers and services in light of recent approval by CMS of the Michelle P Waiver and the Long Term ABI Waiver. A review of the Home and Community Based Services Waiver which provides community based services for the aged/disabled population shows a gap in services between the existing waiver which offers minimal personal care and homemaking and the Nursing Facility. Medical services are provided in the existing HCB waiver only through the Adult Day Health Care service. This gap in services causes some individuals to enter the facility earlier than necessary and prevents some from leaving the facility due to a lack of available services. Kentucky has written a new waiver which contains personal care and homemaking, as well as nursing supports and a residential option. This waiver is being reviewed internally and will be submitted to CMS regional office by July 1, 2008. This waiver will not be restricted only to those transitioning through MFP. It will be available to provide expanded services to those transitioning from Nursing Facilities but will also be available to provide services that may divert others from early Nursing Facility admission. Kentucky intends to make the following waivers available to those transitioning from facilities: the HCB Waiver, the New Aged/Disabled Waiver, the SCL Waiver, the Michelle P Waiver, the ABI Rehab and the ABI Long Term. We want participants to have the option to receive whatever level of services they need depending on their care plan and residential needs. The waiver providing services to the individual will be based on consumer choice and care needs.

At least 2 months prior to the end of the Demonstration Period, each participant will be assessed by their Case Manager to determine level of care for ongoing 1915(c) waiver eligibility. This assessment process will be the existing waiver assessment process for each waiver. This will ensure an adequate amount of time to address problems/issues should they not meet level of care requirements to continue in the HCB Waiver program. The Case Manager will assist them in identifying other programs and resources to support them in the community, including existing DAIL programs.

Kentucky will be reviewing the current assessment process in the existing HCB waiver which requires that assessment for waiver services be completed in the community. This is a barrier to individuals leaving the Nursing Facility in that they have to leave the facility (or hospital) without services in place to complete the assessment process. (This will not affect those transitioning through MFP as they will meet Nursing Facility Level of Care and have Medicaid eligibility prior to transition to Demonstration Services but will impact transitions after the demonstration). Kentucky will revise the assessment process to allow the process to be completed prior to transition to facilitate future transitions. This revision will be made in addition to other revisions to the waivers Kentucky is exploring based on recommendations from a Waiver Standardization

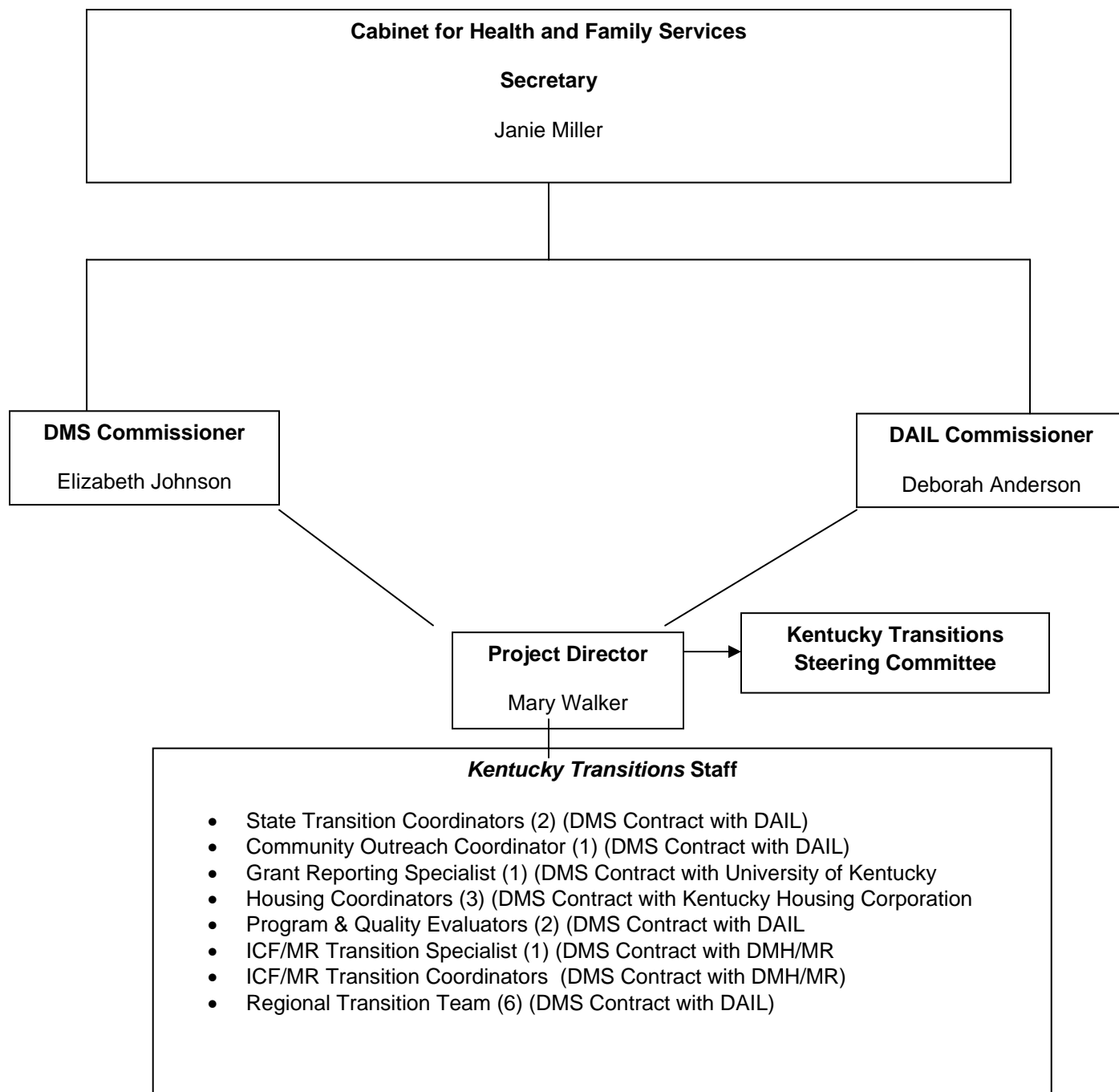
Workgroup (made up of staff, waiver providers and advocates) that met earlier this year. These recommendations standardize service definitions and expand the availability of providers across the waivers.

BILLING AND REIMBURSEMENT PROCEDURES

Payments for transitional services not processed through the states MMIS will be made and tracked through the Enhanced Management Administration and Reporting System (eMARS), the statewide accounting system used by state agencies to produce financial reports and process payments and receipts to or from vendors/contractors.

Payments for services provided through *Kentucky Transitions* (e.g., home adaptations, rent deposits, utility deposits, etc.) will be processed in the eMARS. All vendors who provide services will be required to register with the state as a vendor customer in the eMARS. The state requires each vendor customer to provide information needed to complete their application to become a valid vendor customer. Once the vendor customer is finalized in the system, they may submit invoices for payment of services provided. Invoices submitted by the vendor customer must contain the required information (e.g., a description of the services provided, the billed amount) in order for approval and processing of payments to be completed. Payments will not be approved for processing until signed off by appropriate *Kentucky Transitions* staff. Invoices and signed approval documentation will be maintained by the Financial Division of the Kentucky Department for Medicaid Services.

III. ORGANIZATION AND ADMINISTRATION



STAFFING PLAN

STAFF IN PLACE

- **Project Director:** The Project Director for *Kentucky Transitions* is Mary Walker, Assistant Director of the Division of Long Term Care and Community Alternatives in Medicaid.
- **State Transition Coordinators:** The State Transition Team is made up of two Transition Coordinators who will be located in Central Office and will coordinate transitions throughout the state. One coordinator is a social worker and one is a registered nurse. Together they make up the State Transition Team. The State Transition Coordinators are full time.
- **Community Outreach Coordinator:** One full time coordinator who develops and will implement the Outreach, Education and Training process for MFP.
- **Housing Coordinators:** Kentucky contracts with Kentucky Housing Corporation for three full time Housing Coordinators who are located regionally (east, west and central) across the state. One coordinator is located in central office and the other two positions are located in the Eastern and Western parts of the state.
- **ICF/MR MFP Coordinator:** MH/MR employee hired part time through the grant to assist with coordinating MFP with the existing transition process and assist staff with identifying and resolving barriers to transition.
- **Program and Quality Evaluators:** Two part-time positions hired through the grant to assist with development of Operational Protocol and to do program and quality evaluation of the MFP Program.

To be hired

Grant Reporting Specialist – a full-time employee who will ensure that all data tracking and reporting is in place and that all grant reporting is submitted accurately and within the designated timeframe. This position will be hired through a contract with the University of Kentucky.

Regional Transition Teams- Teams made up of a nurse and a social worker who will facilitate transitions from Nursing Facilities. These Teams will be hired through a contract with DAIL. Kentucky plans to roll out with three Regional Transition Teams and add others as needed.

ICF/MR Transition Coordinators – These positions are currently in place and employed by DMH/MR. DMS will contract with DMH/MR to utilize these existing coordinators in the MFP program.

DMS will contract with the University of Kentucky to provide staff to serve as Regional Transition Coordinators

8/6/2008

STAFFING PLAN

STAFF IN PLACE					
Position	Percentage of time dedicated to grant	Number of Positions	Role/Responsibilities	Funding Source	Hiring Status Effective December 26, 2007
Project Director	1 FTE	One	<ul style="list-style-type: none"> Responsible for completing of all grant tasks and policy decisions. Implements grant tasks and policy Reviews and submits reports Maintains contact with CMS grant officer 	Grant/State Match	Complete
State Transition Coordinators	1 FTE	Two	<ul style="list-style-type: none"> State Transition Team, comprised of a nurse and social worker, with responsibility for the planning for and coordination of the transition of Medicaid members from institutional settings to community settings through <i>Kentucky Transitions</i>. Responsible for developing transition plans and monitoring transitioned participants. 	Grant/State Match	Complete (Contracting with UK)
Community Outreach Coordinator	1 FTE	One	<ul style="list-style-type: none"> Responsible for the identification, planning for, and implementation of the training needs of the staff and consumers for <i>Kentucky Transitions</i>. Responsive to marketing opportunities to include representing the program to the public and development of marketing and outreach materials. 	Grant/State Match	Complete (Contracting with UK)
Housing Coordinators	1 FTE	Three	<ul style="list-style-type: none"> Assist residents of nursing facilities and ICFs/MRDD receiving Medicaid to identify and access permanent, accessible housing in cooperation with the Department of Aging and Independent Living and the Department of Medicaid Services, as well as other partnering service agencies supporting the individual's transition to the community. Establish housing-related policy and procedures and provide ongoing monitoring of the policy and procedures. Work with community service and housing agencies to facilitate partnerships and overcome barriers to permanently housing these clients in the community. 	Grant/State Match	Complete (Contracting with Housing)

			<ul style="list-style-type: none"> • Provide community education and attend collaborative meetings with Department for Independent Living, the Department of Medicaid Services, Kentucky Housing Corporation, and other supportive housing entities to promote permanent, accessible housing for the targeted population groups. • Perform other duties related to supportive housing. 		
ICF/MR MFP Coordinator	.20 FTE	One	<ul style="list-style-type: none"> • Coordinates with MFP team related to existing ICF/MR transition process and how it relates to the MFP program. • Assists MFP staff in identifying and resolving barriers related to transitions from ICF's/MR. 	Grant/State Match	Completed (Contracting with MH/MR)
Program and Quality Evaluation	.25 FTE	Two	<ul style="list-style-type: none"> • Assist in develop of Operational Protocol • Program and Quality evaluation 	Grant/State Match	Complete (Contracting with DAIL)

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IV. EVALUATION

Kentucky did not propose a formal evaluation of the *Kentucky Transitions* project; thus, this section of the Operational Protocol does not apply. At this time, Kentucky will rely on the evaluation activities of the national evaluator, Mathematica. If unmet evaluation needs are identified, Kentucky will propose an amendment to this Operational Protocol.

V. BUDGET

See Attachment 19 - Budget

VI. STATE SPECIFIC TERMS AND CONDITIONS

State-Specific Terms and Conditions

At the request of CMS, the following state-specific terms and conditions have been addressed in the Operational Protocol:

- (1) Provide more information as to the services that will be proposed under the demonstration and the State's plan to sustain these services after the demonstration ends.

This information is addressed in the Benefits and Services and Continuity of Care Sections of the Operational Protocol.

- (2) Explain the collaboration, future roles, and possible impact on institutional providers during implementation of *Kentucky Transitions* and after the demonstration relative to sustainability needs (e.g., transfer 50% of institutional semi-variable costs, 100% of variable costs).

Kentucky views *Kentucky Transitions* as slowing the growth rate of institutional placements and reducing the number of new facility beds needed as the population ages. For example, the community placement of approximately 400 nursing facility residents over the 5-year *Kentucky Transitions* program represents less than two percent of residents per nursing facility. This will not have a substantial impact on the operational cost of the average nursing facility. Kentucky's Price-Based Reimbursement System will accommodate increased per resident cost of care for the remaining nursing facility residents. It will allow increased payments to nursing facilities due to higher acuity levels which will partially offset the lost reimbursement as *Kentucky Transitions* participants move out and will provide an available bed in the future as the demographics and needs change for our aging population. This could hold down rate increases in the future as the availability of nursing facility beds creates a surplus in the marketplace. Nursing facilities will be sustained by increases in the average acuity level of the patients as lower care residents are returned to or remain in the community longer through *Kentucky Transitions* and subsequent community placement waivers.

- (3) Provide more information regarding the actual number of staff to be hired for the *Kentucky Transitions* demonstration (i.e., full-time equivalents or percent of) and the respective job descriptions.

This information can be found in the Staffing Plan within the Organization and Administration Section of the Organizational Protocol.

- (4) Explain how the Area Agencies on Aging/Independent Living (AAA/ILs) will be able to serve the needs of the younger populations transitioned in the demonstration, in addition to the elderly, since the AAAs are the Support Brokers for waiver participants in all aspects of self direction.

AAA's are currently serving as Support Brokers for all waiver populations in Kentucky and are assisting the HCB, SCL and ABI populations.

VII. ATTACHMENTS